

Waltham Forest Joint Strategic Needs Assessment (JSNA) Refresh 2014/15



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Waltham Forest
Clinical Commissioning Group

In
partnership
with



Waltham Forest

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Introduction and summary

Introduction

Joint Strategic Needs Assessments (JSNAs) are a way of examining and understanding the health needs of local people, in particular to highlight issues important for improving the health and wellbeing of the local population and for reducing inequalities. JSNAs can be used by local people and organisations for identifying local actions. Our aim is to develop a JSNA that is a foundation for:

- a. Supporting the commissioning of health and wellbeing services and assisting in identifying priorities for the local Health and Wellbeing Board and Clinical Commissioning Group;
- b. Identifying key areas where the actions of local partners such as the Local Authority, NHS, voluntary and community sector can best improve health;
- c. Informing the public about the key health issues locally and where as individuals they may wish to take action to improve their own health;
- d. Providing others (such as local businesses) with material to examine their own contribution to improving health.

This JSNA is a refresh of work done in 2012 and is the first produced since the 2013 reforms which transferred responsibility for Public Health into the Local Authority. It does not cover all health topics, but provides a range of information on the health and wellbeing of the people of Waltham Forest and how that compares with other Local Authorities, as well as with London and England averages. We will be developing this work further in the next year to ensure it achieves all the aims set out above and is updated on a more frequent basis as more evidence becomes available. It has not been possible to consult widely on this refresh, but we welcome comments at any time, sent to Nicola.pearce-mcginn@walthamforest.gov.uk

The rest of this chapter contains a summary of some of the key findings, particularly where Waltham Forest compares poorly with the rest of the country and action may be considered. It also provides a short explanation of the 2011 Census and the resulting population figures, which have had an effect on a number of areas in this JSNA. The subsequent individual chapters of the JSNA include a much wider range of detail and information and each is available as a download.

Summary of key findings – areas where Waltham Forest compares poorly or well against England

Compared to England, Waltham Forest has high numbers of children in poverty (estimated at 16,800 children); 23.5% of Year 6 children are obese; there are high numbers of statutory homeless, poorer GCSE attainment, higher levels of violent crime and high numbers of long-term unemployed.

Waltham Forest compares well to other boroughs across England on initiating breast-feeding, low rates of women smoking in pregnancy, higher numbers of adults eating healthier food, and lower numbers of road injuries and deaths¹.

Issues affecting children and families

Infant mortality rates are high compared to England (2009–11).

Child Wellbeing index is ranked below the England average (2009).

Immunisations are high but do not meet the WHO target in some cases, for example 2nd MMR which currently stands at 85.6% at age 5 compared to a WHO target of 95% coverage.

Waltham Forest is estimated to have the second highest rate per 1,000 of congenital and genetic birth disorders in London.

Despite a large reduction in teenage pregnancy rates over the last few years, they remain high.

Self-harm related emergency hospital admission rates amongst under 19s are higher than London (2011/12).

Inpatient admission rate per 100,000 aged 0 to 17 years for mental health disorders greater than 3 days duration are higher than London and England (2011/12).

Percentage with special educational needs in schools is higher than London and England average.

The number of Looked After Children receiving their health assessments has dropped from 92% in 2011/12 to 76% in 2012/13.

Adults: smoking, substance misuse, alcohol and obesity

Waltham Forest has high rates of hospital admission for alcohol and the trend is upwards, with admissions for men significantly higher than London and England. About 20% of Waltham Forest residents have been identified as at risk drinkers.

Waltham Forest has high numbers of drug users with Hepatitis C virus, with over 50% of intravenous drug users injecting in 2012 Hepatitis C positive.

Around 21% of the population smoke. Smoking attributable hospital admissions are amongst the highest in the country. Use of stop smoking services is declining.

Around 9% of the adult population is obese, below the level for England.

¹ These figures taken from the 2013 Waltham Forest Health Profile. The source data varies by year.

Infectious disease

The number of cases of Tuberculosis (TB) is high and rising, currently at 50 cases per 100,000 compared to a London wide rate of 44 cases per 100,000. Diagnosis in A&E indicates that TB is being diagnosed at a late stage. This is an important and urgent local issue.

Young people are those most likely to be affected by a sexually transmitted disease, in particular chlamydia and gonorrhoea (16 to 24-year-olds). Waltham Forest ranked 15th highest out of all local authorities for rates of sexually transmitted infections in 2012.

HIV is more predominant in the over 25 age group. 802 people accessed services for HIV locally in 2011. A high number of people are not diagnosed early with HIV (47% of diagnoses made in 2011). This delayed access to treatment leads to lower life expectancy, the potential for more serious illness during the course of the illness and a higher need for health and social care services.

Long-term conditions

Diabetes remains a significant problem for the community, with Quality and Outcomes Framework (QOF) recording 5.9% of the population in total. This is considered an under recording of the true prevalence, with over 6,500 further people in the borough estimated to be undiagnosed.

The estimated number of all deaths attributable to diabetes for those aged 20 to 79 in Waltham Forest is 14.6%, similar to other boroughs in outer and inner north east London but much higher than in England².

The incidence of all cancers has risen in the years 2008–10. Cancer mortality is higher in the borough than England. There is poor 5-year survival which is probably due to poor awareness of signs and symptoms amongst segments of the local population.

Prostate cancer incidence is much higher than London as a whole and England (2010), but lung, bowel and breast cancer are either lower than London or similar. Uptake of screening is in line with London rates, although similarly to the rest of London, lower than national targets.

The association between deprivation and prevalence of coronary heart disease in London remains strong, with Waltham Forest having a higher prevalence of Coronary Heart Disease (CHD) at all ages, comparable to other boroughs with high Index of Multiple Deprivation scores (high relative deprivation).

GP registers (2011/12) record 2.08% of the population as having CHD. This is estimated to be about 35% of the true rate (estimated at 6.03%).

Cardiovascular disease remains the biggest killer of those aged 75 and under, and there are significantly higher rates in the poorer wards compared to more affluent areas.

The increase in older black, asian and minority ethnic (BAME) populations in the borough is important to plan for because these groups are more at risk of Cardiovascular disease.

² Statistics from this point are taken from the London Needs Assessment Toolkit on the Public Health England website accessed October 2013. Statistics are refreshed at varying intervals – all data quoted is the most recent made available.

Older people, social care needs and end of life care

Admissions to hospital for falls remain significantly higher in Waltham Forest than in London and comparator boroughs. Implementing the Falls Prevention Strategy remains crucial. Mortality from fracture of femur is higher than comparators.

There were on average 87 excess winter deaths per year in Waltham Forest between 2008–11. This represents a ratio of excess winter deaths of 25.9 for Waltham Forest, which is above the London average of 21.8 and England average of 20.9. For every additional winter death nationally, there are also around 8 admissions to hospital, 32 visits to outpatient care and 30 social services calls.

The number of people diagnosed with dementia in Waltham Forest is 987 which is 0.34% of the estimated population. Despite the relatively low recorded prevalence, emergency admission rates for dementia in Waltham Forest from 2009/10 to 2011/12 were consistently higher than London and national rates.

The 2013/14 GP palliative registers show that there 465 patients on the register, which means the palliative registers in primary care captures less than half (47%) of the people needing palliative care. That means people who require palliative care may potentially not receive the care they need.

A recent survey on public preferences for place of death shows 89% of the participants wanted to die at home or in a hospice. Hospital deaths in Waltham Forest is rated the highest in the country at 70.2%; compared to London 61% and England 54.5%.

Mortality

All-cause mortality rates have fallen in last 10 years. There continues to be a reduction in the number of people dying from stroke or heart disease. The SMR³ for Waltham Forest is 100.32 – higher than for London, lower than outer north east London – but the rate for Lea Bridge ward is much higher, at 170.33 (2006–10).

2011 Census and the population data

This JSNA refresh has been produced at a time when new figures are emerging from the 2011 Census, which has a higher estimate for the borough's population than either the 2001 Census or earlier estimates for 2011. In general we have used the 2012 mid-year population estimated as the basis for our calculations but in some cases, where detailed breakdowns are required, earlier figures are used where they give a more reliable picture of the particular issue being examined.

The increased population has in addition resulted in revised estimates of life expectancy in the borough which is now close to the London and England figures for both men and women. The full implications of these changes on the data are being worked through and will be included in the next JSNA. Further details on this including the effects on life expectancy are included in Chapter 2.1 of this JSNA, and a fuller description of the population changes is available on the Local Authority website under 'Statistics about the Borough'.

³ SMR – similarly to the Standardised Admission Ratio the Standardised Mortality Ratio compares Waltham Forest with England, comparing observed with expected deaths.

A comparison of the different population estimates used is given below.

Table 1.1 **Population estimates**

Population	Numbers
2011 Census Population (as at Census day March 2011)	258,249
2011 Mid – Year Population Estimate (based on the 2011 Census)	259,742
2012 Mid – Year Population Estimate (based on 2011 Census)	262,566

Population

The 2011 Census records a population of 258,249 persons living in the borough in 96,861 households. The borough has a similar age structure to London as a whole with a larger percentage of children and people aged 20 to 39 than the England and Wales average.

The 2011 Census data show that Waltham Forest's BAME (black, asian and minority ethnic) population is 123,450. This is the 13th highest across the London boroughs and the 8th highest when expressed as a percentage of total population (47.8%). This is higher than the estimated BAME population reported in last year's JSNA. In the 0 to 19-year-old population, 62.4% are from a BAME group.

Population projection

Population projections based on the 2011 census for the year 2021 suggest notable increases. There will be around 13,156 more children (0 to 14 years), 2,086 fewer people aged in the range of 16 to 23 years and 2,410 more people above the current state pension age (over 65s) living in Waltham Forest by 2021. The overall increase in population between 2011 and 2021 is projected to be around 32,614, a 12.6% increase.

Deprivation

Deprivation has increased in Waltham Forest, both relatively (i.e. compared to other boroughs) and absolutely. There are increased numbers of families and individuals in receipt of benefits and applying for social housing (comparing 2009–11 population databases for the borough).

2

Waltham Forest and its people

2.1 The people

The most recent population estimate based on the 2011 Census data has given the borough a population of 262,566 (as at June 2012) persons living in 96,861 occupied households.⁴ This is a higher estimate for the borough's population than either the 2001 Census or earlier estimates for 2011/12. This has an effect in a number of areas of the JSNA which are discussed in the relevant chapters. The impact on life expectancy is discussed below.

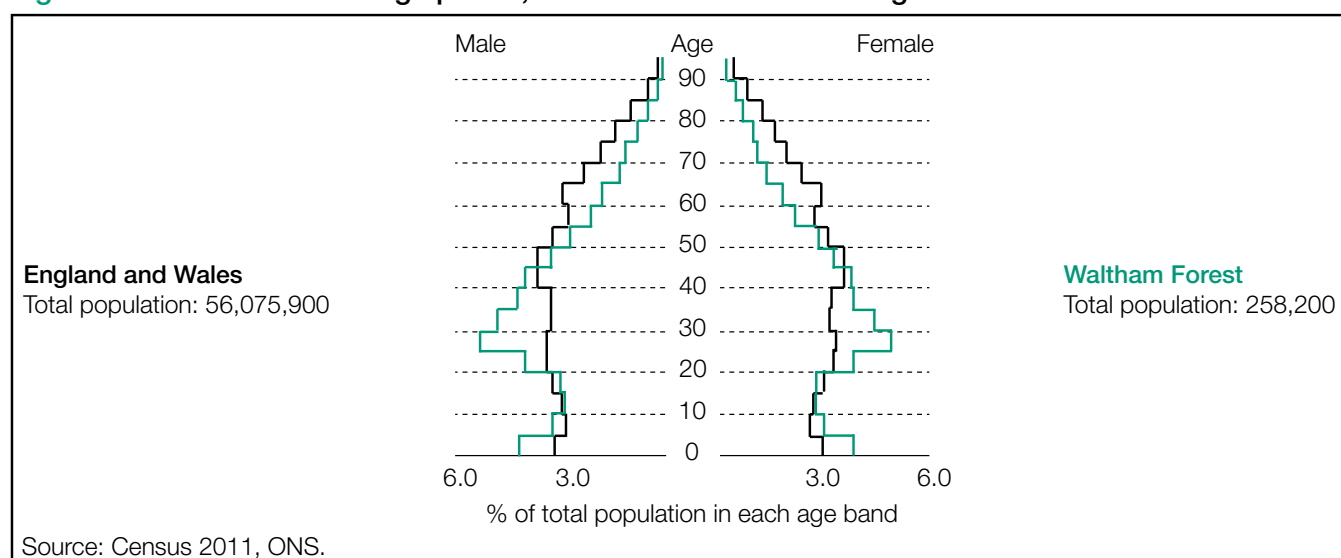
Population density tends to be higher in the middle and southern wards of the borough compared to the northern wards. In terms of ethnicity the middle and southern wards of the borough also tend to be more diverse whilst a higher percentage of the borough's white population is found in the northern wards.

In summary, just over half the borough is female (50.1%) and the borough has a similar age profile to London as a whole. The largest number of households in the borough is single households (30% of all households) which is similar to London (32%). 35% of all households have dependent children.⁵ Data on arrivals from other countries show that Pakistan, Lithuania and Poland have supplied the greatest number of migrants.⁶

Population by age, gender and ethnicity

Data from the 2011 Census reveals that the gender split in the borough is almost 50:50 with 50.1% of the population being female. The borough has a similar age structure to London as a whole with a larger percentage of children and people aged 20-39 than the England and Wales average. Residents aged 45 and over comprise a smaller proportion of the population than the England and Wales average, similar to the London profile. Figure 2.1 below shows the distribution of the population in Waltham Forest compared to England and Wales whilst Figure 2.2 shows the number of residents by gender and age group.

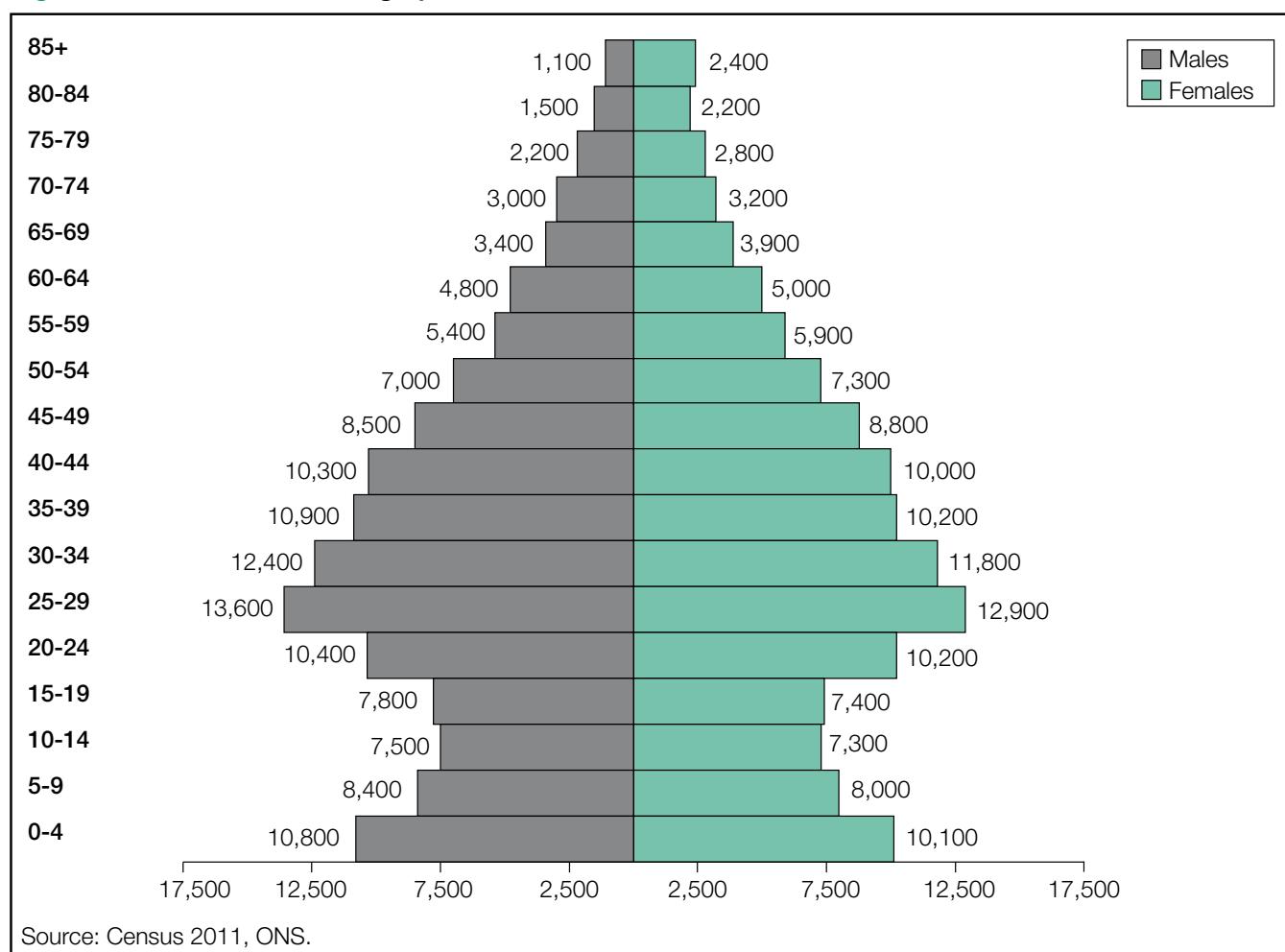
Figure 2.1 2011 Census age profile, Waltham Forest versus England and Wales



⁴ Office for National Statistics 2011 Census © Crown Copyright 2013.

⁵ Nomis – Tenure by household size, http://www.nomisweb.co.uk/census/2011/detailed_characteristics

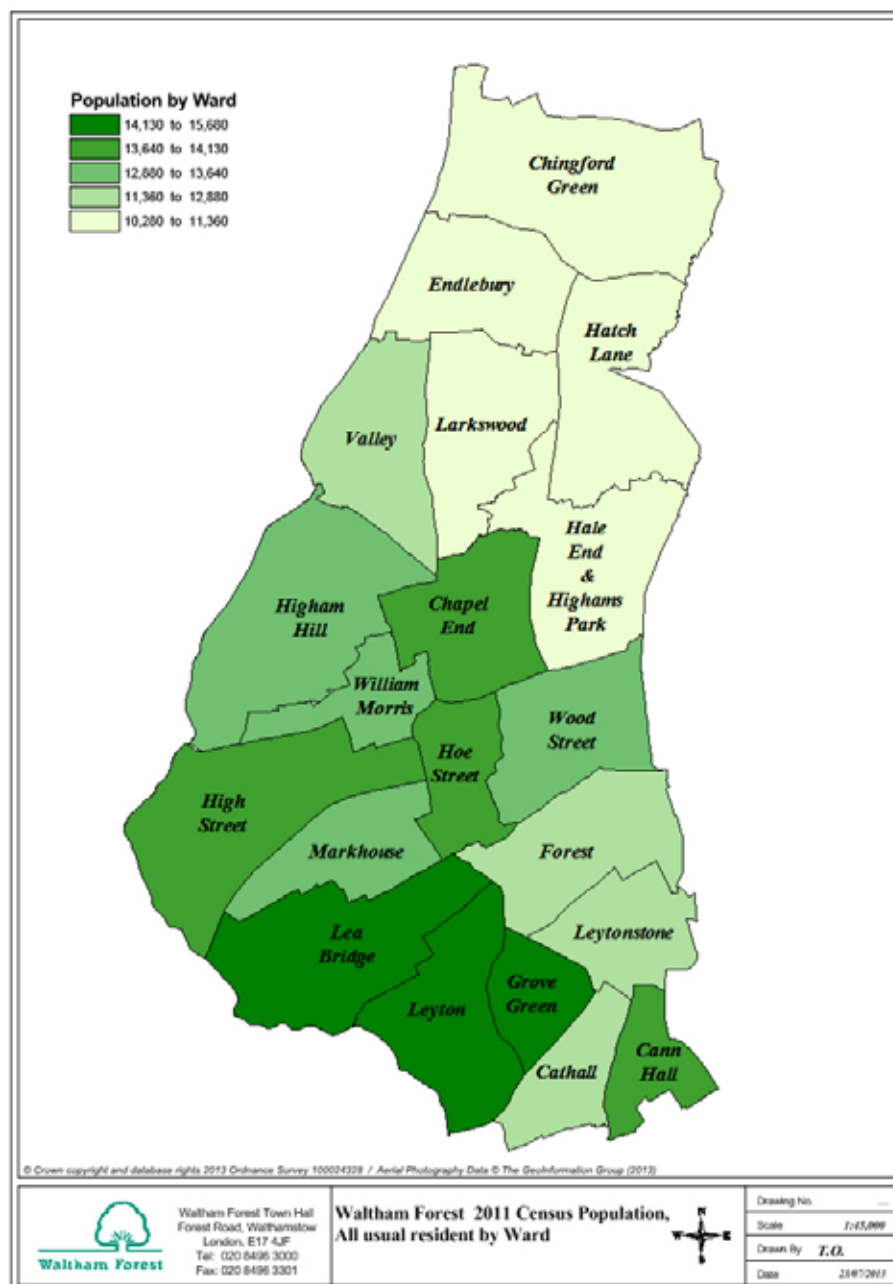
⁶ Nomis – Tenure by household size, http://www.nomisweb.co.uk/census/2011/detailed_characteristics

Figure 2.2 2011 Census age profile, Waltham Forest

Population by ward

Figure 2.3.a shows that the middle and southern wards of the borough tend to have larger populations whilst the northern wards tend to have smaller populations.

Figure 2.3.a Waltham Forest ward population, 2011 Census

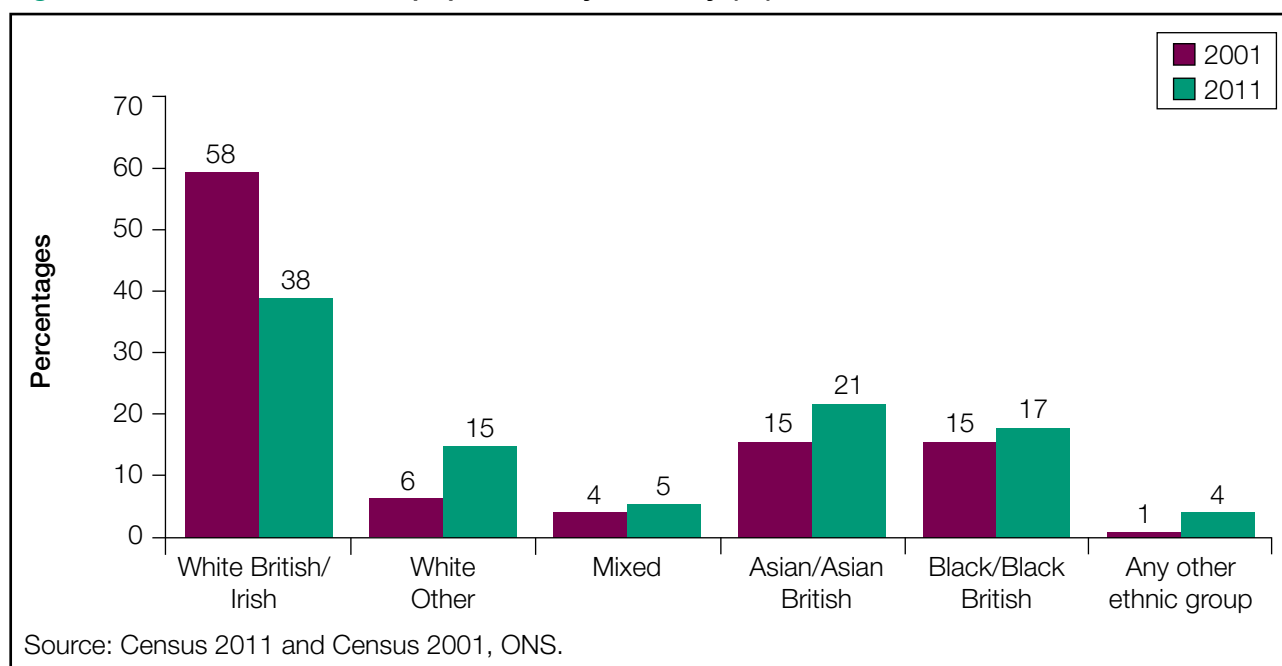


Source: Census 2011, ONS.

Ethnicity

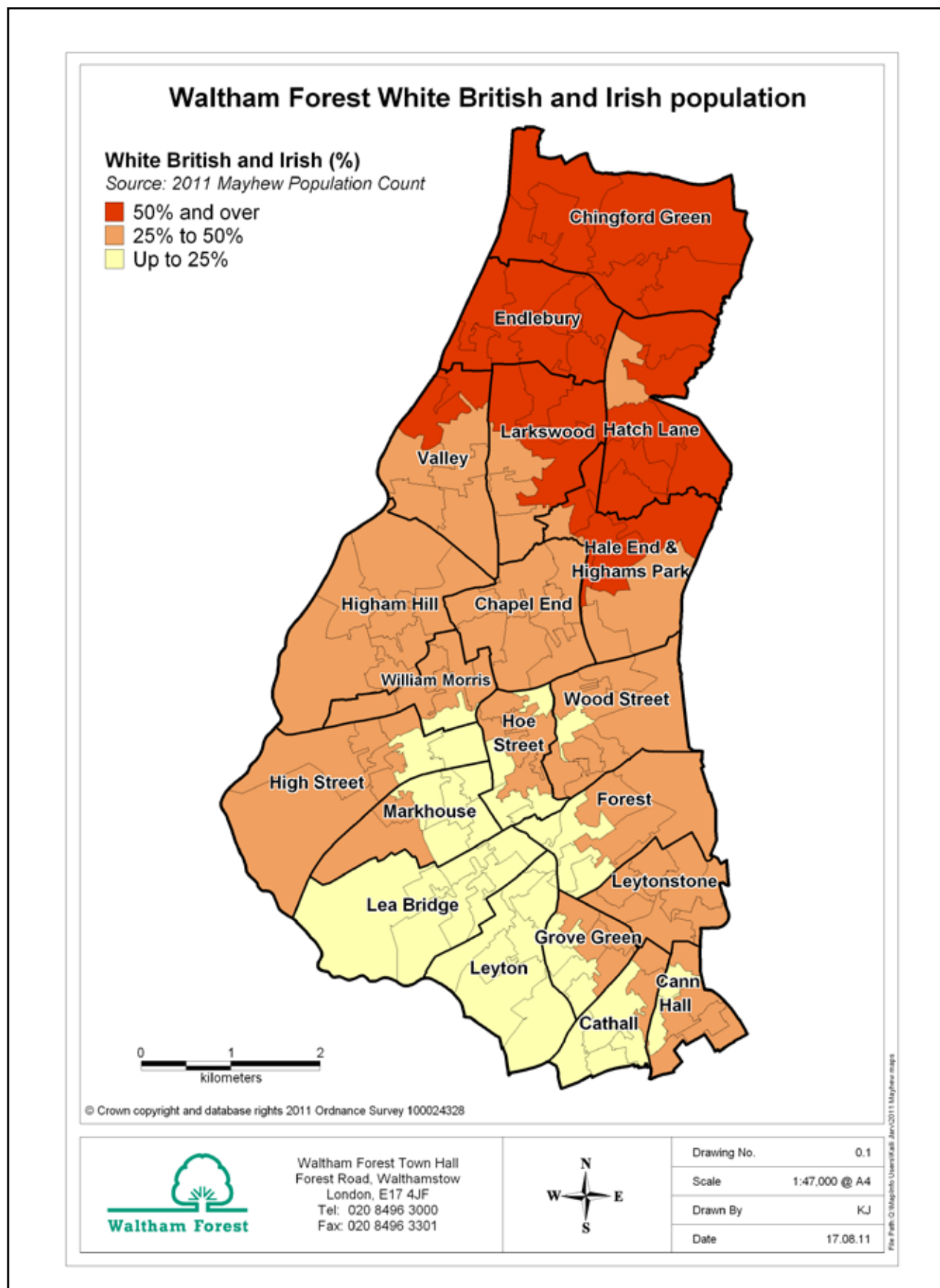
The 2011 Census data show that Waltham Forest's BAME (black, asian and minority ethnic) population is 123,450. This is the 13th highest across the London boroughs and the 8th highest when expressed as a percentage of total population (47%). When expressed as a percentage of the population as a whole the BAME data is distributed thus: mixed: 5%, black/black British: 17%, Asian/Asian British: 21%, other ethnic group: 4%.⁷

⁷ Office for National Statistics (ONS), 2011 Census.

Figure 2.3.b Waltham Forest population by ethnicity (%), in 2001 and 2011

Data from an alternative source (the 2011 Mayhew population count) show that the distribution of the borough's white British and Irish population tends to be focused more in the northern wards of the borough compared to the central and southern wards. See Figure 2.4.

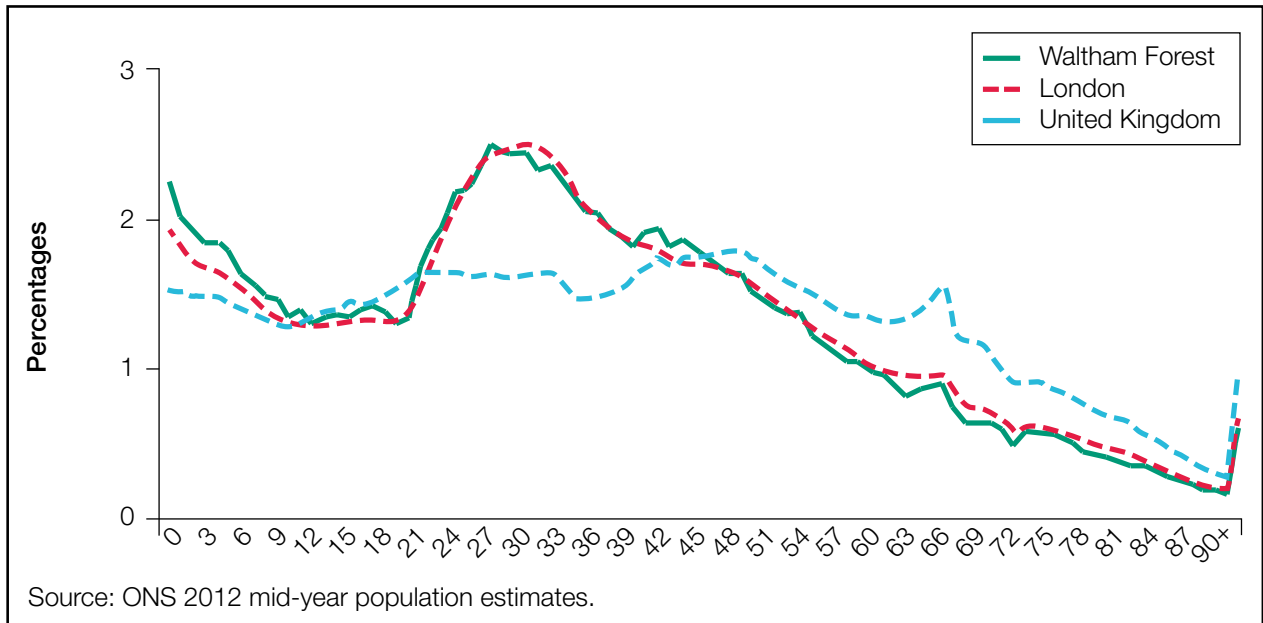
Figure 2.4 Waltham Forest ethnic diversity



Population projections

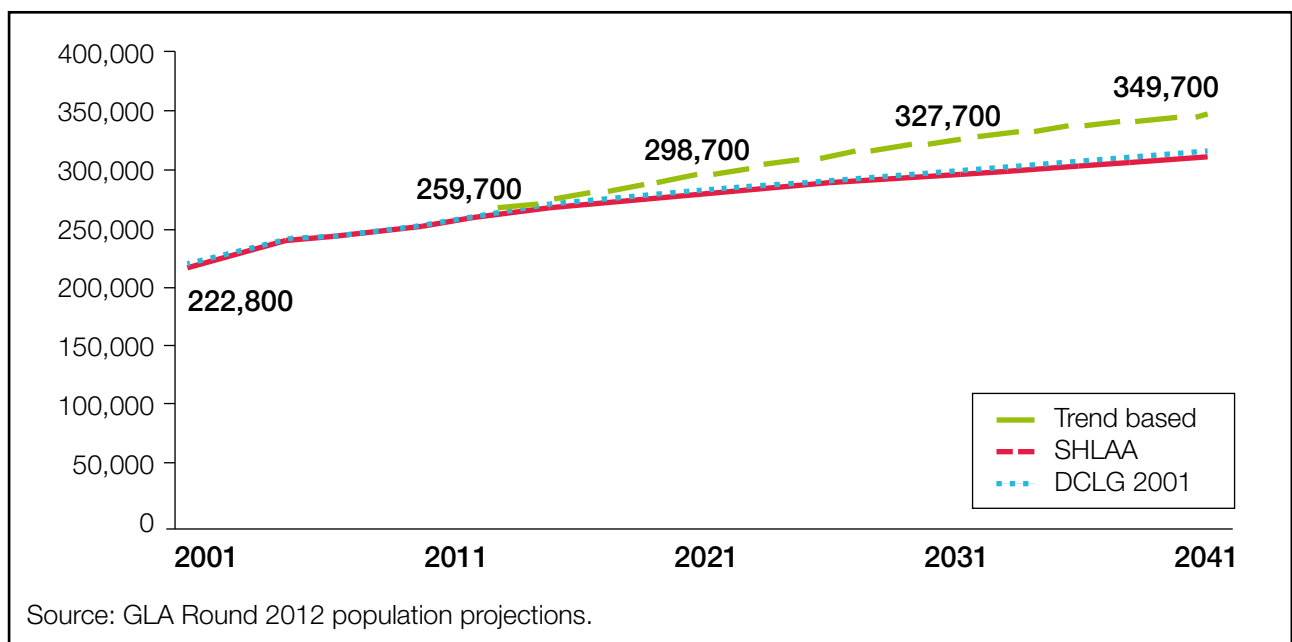
Waltham Forest has a younger than average population with higher proportion of children aged 0 to 15 as seen on Figure 2.5 (22% compared to 20% in London and 19% nationally). Similarly to London, Waltham Forest has a high proportion of young working-age adults aged 25 to 49 (42% compared to 34% nationally). Conversely, there are proportionately less people aged over 50 living in Waltham Forest (24%) and London as a whole (26%) compared to the UK average (35%).

Figure 2.5 Population structure by single year of age



The borough's population is projected to continue to rise over the next three decades by between 55,000 and 90,000 people depending on the projection variant (see Figure 2.6). This means that according to the highest (trend-based) projection Waltham Forest could have almost 300,000 residents by 2021 and almost 350,000 by 2041 (35% growth from 2011).

Figure 2.6 Population projections for Waltham Forest



Most public health indicators (e.g. mortality, morbidity, births, admissions) where used as rates are calculated using the population as a denominator. Therefore changes in the population size affect the values of the indicators. For example, if the population increases with the same number of deaths, mortality would decrease.

As the 2011 Census population for Waltham Forest shows an increase compared to recent estimates based on 2001 Census this will have an impact on indicators used in this JSNA. In other words, these indicators may change when they are calculated using the 2011 Census population. Where relevant these figures will be updated as they are recalculated using the new Census data.

Population turnover (in- and out-migratory moves)

The most significant element of migration for Waltham Forest is from and to other London boroughs. Neighbouring boroughs prove to be the most popular source of in-flows and of those moves registered at the end of June 2011, some 1,530 came from Newham, 1,260 from Hackney, 970 from Redbridge and 890 from Haringey.

Out-flows from Waltham Forest share a similar geography with 1,980 going to Redbridge, 1,500 to Newham, 580 to Enfield and 570 to Barking and Dagenham.⁸

Recent arrivals

Data from the Department for Work and Pensions on those registering for a National Insurance number is useful in estimating the relative scale of different arrivals into the borough. This data does need careful interpretation since it is only a measure of inflows and does not take into account those who have subsequently left the borough. Waltham Forest recorded just over 10,500 National Insurance number (NINo) allocations to adult overseas nationals entering the UK in 2012/13.⁹ This was the tenth highest number for any borough in the country. There were 8,616 new migrant registrations with GPs in Waltham Forest during 2012.

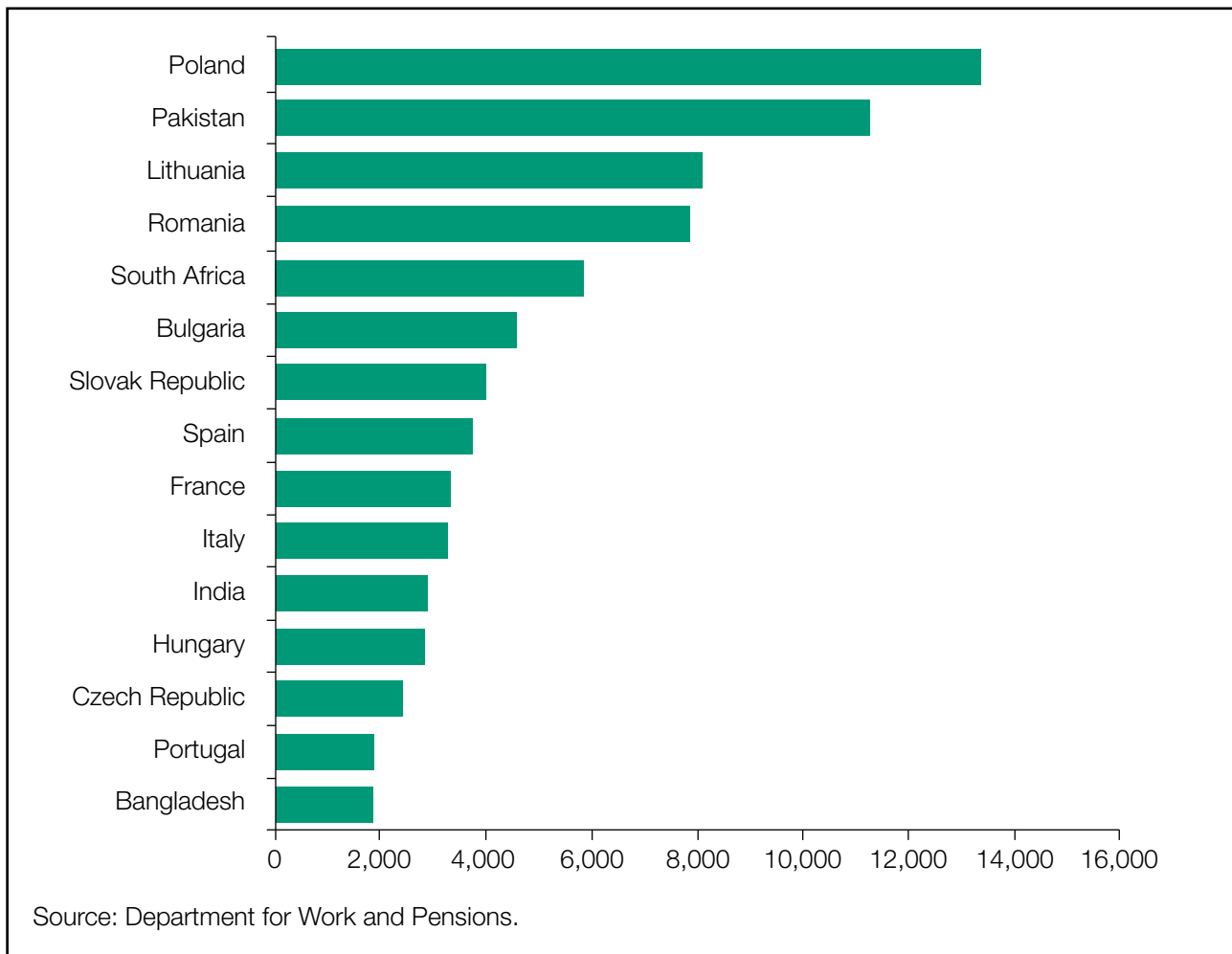
The data show that the greatest number of National Insurance registrations in the borough between January 2002 and March 2013 have come from residents originally from Poland (13,394), followed by Pakistan (11,241) and Lithuania (8,116). Other arrivals from Eastern Europe include Romania (7,845) and Bulgaria (4,573). South Africa is the fifth highest ranked source at 5,872 (see Figure 2.7).¹⁰

⁸ ONS Migration Statistics Unit (Moves registered during the year ending June 2011).

⁹ National Insurance number allocations to adult overseas nationals entering the UK – registrations to March 2013 ONS August 29th 2013.

¹⁰ DWP, National Insurance registrations to adult overseas nationals entering the UK from 2002 to June 2011.

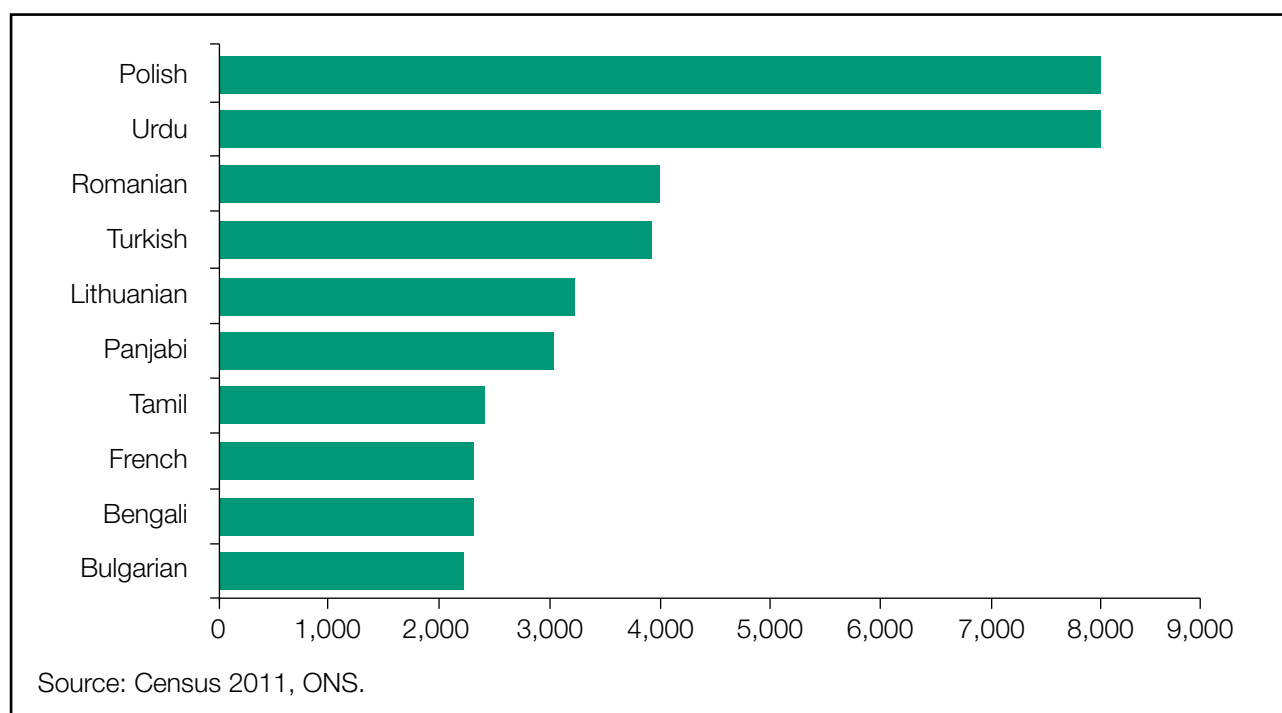
Figure 2.7 New arrivals to Waltham Forest from 2002 to March 2013 NINo registrations to adult overseas nationals entering the UK: Top 15 nationalities registered in Waltham Forest



Languages spoken

Over a quarter of residents aged 3 and over (26%) do not speak English as their main language compared to 8% nationally. The majority of them (78%) can speak English very well or well. A total of 14,250 people (6% of the resident population) have said that they don't speak English well or at all.

See Figure 2.8 for the top 10 languages spoken in Waltham Forest.

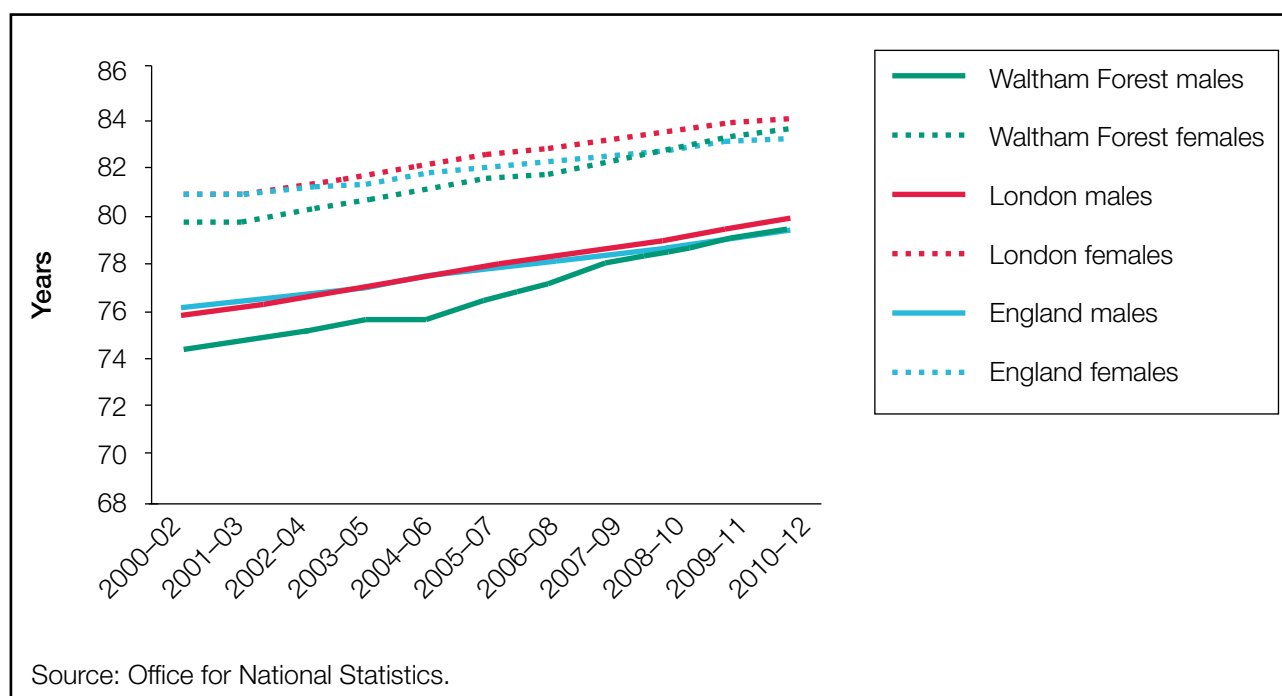
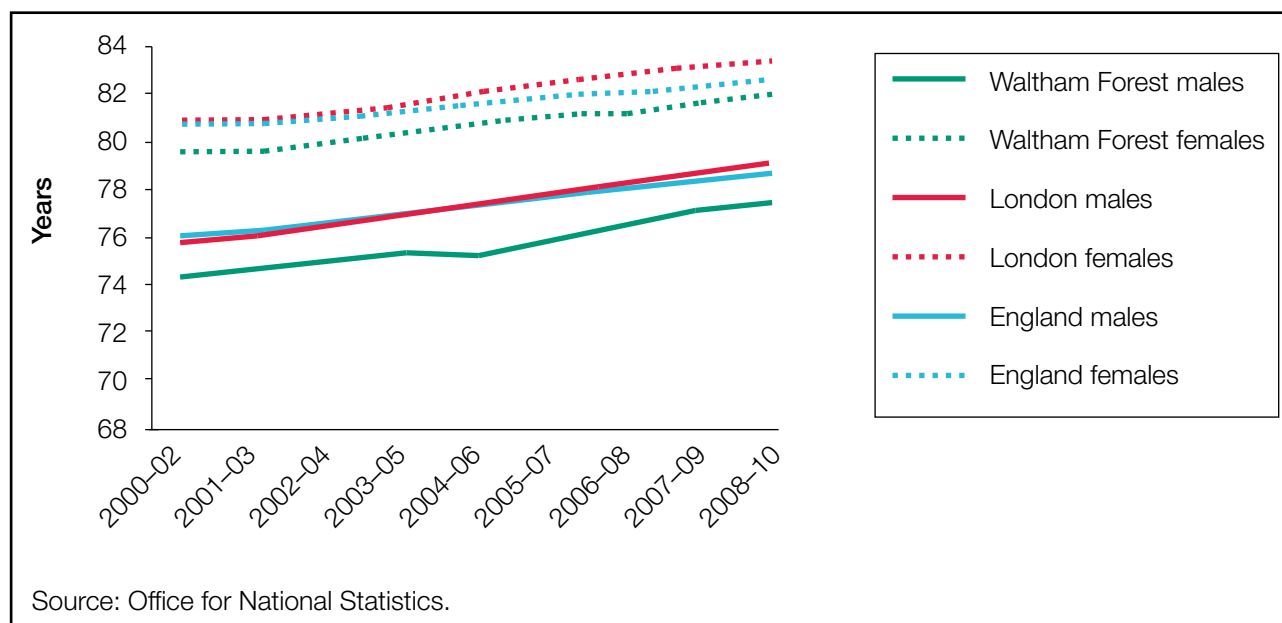
Figure 2.8 Top ten languages other than English spoken in Waltham Forest

Life expectancy

Life expectancy for both males and females in Waltham Forest has been increasing since 2000, in line with national trends. Figure 2.9 shows life expectancy in Waltham Forest up to 2012.

A number of factors influence life expectancy. The higher estimates of the population of Waltham Forest as a result of the 2011 Census have also resulted in the calculation of higher life expectancy figures for the borough.

Figure 2.9 uses the 2011 Census population which is 259,742. This shows that the life expectancy gap between Waltham Forest and the London and England averages has reduced compared to Figure 2.10 which uses the population estimates based on 2001 Census.

Figure 2.9 Life expectancy trends by gender in Waltham Forest, based on 2011 Census**Figure 2.10** Life expectancy trends in males and females in Waltham Forest, based on 2001 Census (rolled forward)

Family types

The total number of households in Waltham Forest is 96,861 with an average 2.66 people living in each household. The most common types of households are single (29.7%), married or in a registered same sex civil partnership (27.8%), and lone parents (13.7%).¹¹ As a proportion of the borough's population, most people live in either family households with dependent children (35%) or cohabiting households without children (4.4%). A significant number lives in single parent households (13.7%).¹²

Lesbian, gay, bisexual and transgender (LGBT) population

Statistics for the size and composition of the LGBT population in Britain remain imperfect due to the lack of robust national data. Estimates range from 0.3% to 10% depending on the measures and sources employed.

The Office for National Statistics has developed a sexual identity question that was included in the Integrated Household Survey (IHS) in 2009. The first results from this survey suggest that 0.9% of the population surveyed classified themselves as gay/lesbian with a further 0.5% bisexual. Extrapolating the national figures to a projected borough population of 262,566 would suggest that Waltham Forest has a LGBT population of around 3,700.¹³

However, a recent study commissioned by Waltham Forest, aimed at gaining a greater understanding of local LGBT population, suggested the number of lesbian, gay, or bisexual people in the borough to be somewhere between 7,000 and 10,000 people in 2007 (4-6% of the adult population).¹⁴

It is much harder to obtain information about transgender people due to the ambiguity in the definitions and the low prevalence of transgender persons in the population. The above-mentioned study on LGBT people in Waltham Forest suggests that there might be at least 35 transgender individuals living in the borough.¹⁵

A number of health issues disproportionately affect LGBT populations:

- 1 in 10 men who have sex with men are living with HIV, and 1 in 3 HIV positive men (in major UK cities) have undiagnosed HIV infection¹⁶
- Illicit drug use amongst lesbian, gay and bisexual (LGB) people is at least eight times higher than in the general population¹⁷
- Around 25% of LGB people indicate a level of alcohol dependency
- Nearly half of LGBT individuals smoke, compared with a quarter of their heterosexual peers¹⁸
- Lesbian, gay and bisexual people are at higher risk of mental disorder, suicidal ideation, substance misuse and deliberate self-harm¹⁹
- 41% of trans people reported attempting suicide compared to 1.6% of the general population.²⁰

¹¹ Nomis – Tenure by household size, http://www.nomisweb.co.uk/census/2011/detailed_characteristics

¹² Nomis – Tenure by household size, http://www.nomisweb.co.uk/census/2011/detailed_characteristics

¹³ Measuring sexual identity: An evaluation report September 2010, Office for National Statistics

¹⁴ Waltham Forest LGBT matters. The needs and experiences of lesbians, gay men, bisexual and trans men and women in Waltham Forest. Draft research report. Sigma Research, September 2009.

¹⁵ Waltham Forest LGBT matters. The needs and experiences of lesbians, gay men, bisexual and trans men and women in Waltham Forest. Draft research report. Sigma Research, September 2009.

¹⁶ Dodds J., Johnson A *et al.*, (2007) 'A tale of three cities: Persisting high HIV prevalence, risk behaviour and undiagnosed infection in community samples of men who have sex with men'.

¹⁷ University of Central Lancashire and the LGF, 'Part of the Picture: Year 2 Initial findings' (awaiting publication).

¹⁸ Out House, (2004), I Count: Identifying the need of Nottinghamshire's LGBT communities.

¹⁹ King M, Semlyen J, see Tai S *et al.* (2008) Mental disorders, suicide and deliberate self-harm in lesbian, gay and bisexual people. London: National Mental Health development Unit.

²⁰ National Transgender Discrimination Survey Report on health and health care. Jaime M. Grant, Lisa A. Mottet, *et al.* National Center for Transgender Equality 2010.

2.2 The place

Physical environment

Open spaces and the physical environment have particular roles to play with respect to encouraging healthy lifestyles. In an urban area with little access to countryside they represent one of the few places for outdoor exercise and relaxation on mental health. Of particular significance are the:

- Regional parks for longer walks, horse-riding and cycling
- Local parks and open spaces for general exercise and wellbeing, informal sport and children's play
- Playing fields for organised sports
- Allotments for exercise and healthy food.

Local picture

With 31% of the land area consisting of open space, Waltham Forest is a very green borough. It is in a unique position of being surrounded by open land and countryside of Epping Forest and the Lea Valley, which run the length of the eastern and western boundaries respectively.

Large proportions of the borough are designated as either Green Belt or Metropolitan Open Land, affording them a high degree of protection. Other open spaces within the borough are also given varying degrees of protection through planning policies contained within the Unitary Development Plan. There are a series of smaller local open spaces including outdoor sports facilities, parks and gardens, and allotments which together occupy significant areas, further emphasising the open character of the borough and the availability of land for recreational uses. The borough is unusual in that it has no metropolitan or district parks, however, it is recognised that the two regional parks (Epping Forest and Lee Valley Regional Park) also serve metropolitan, district and local functions for residents of the borough and beyond.

Although the borough is well served for public open space, a relatively small proportion (just over 7%) of the borough is deficient in terms of access to open space. See Figure 2.11. A significantly larger proportion of the borough is deficient in access to local play facilities. See Figure 2.12.

Figure 2.11 Open Spaces Strategy

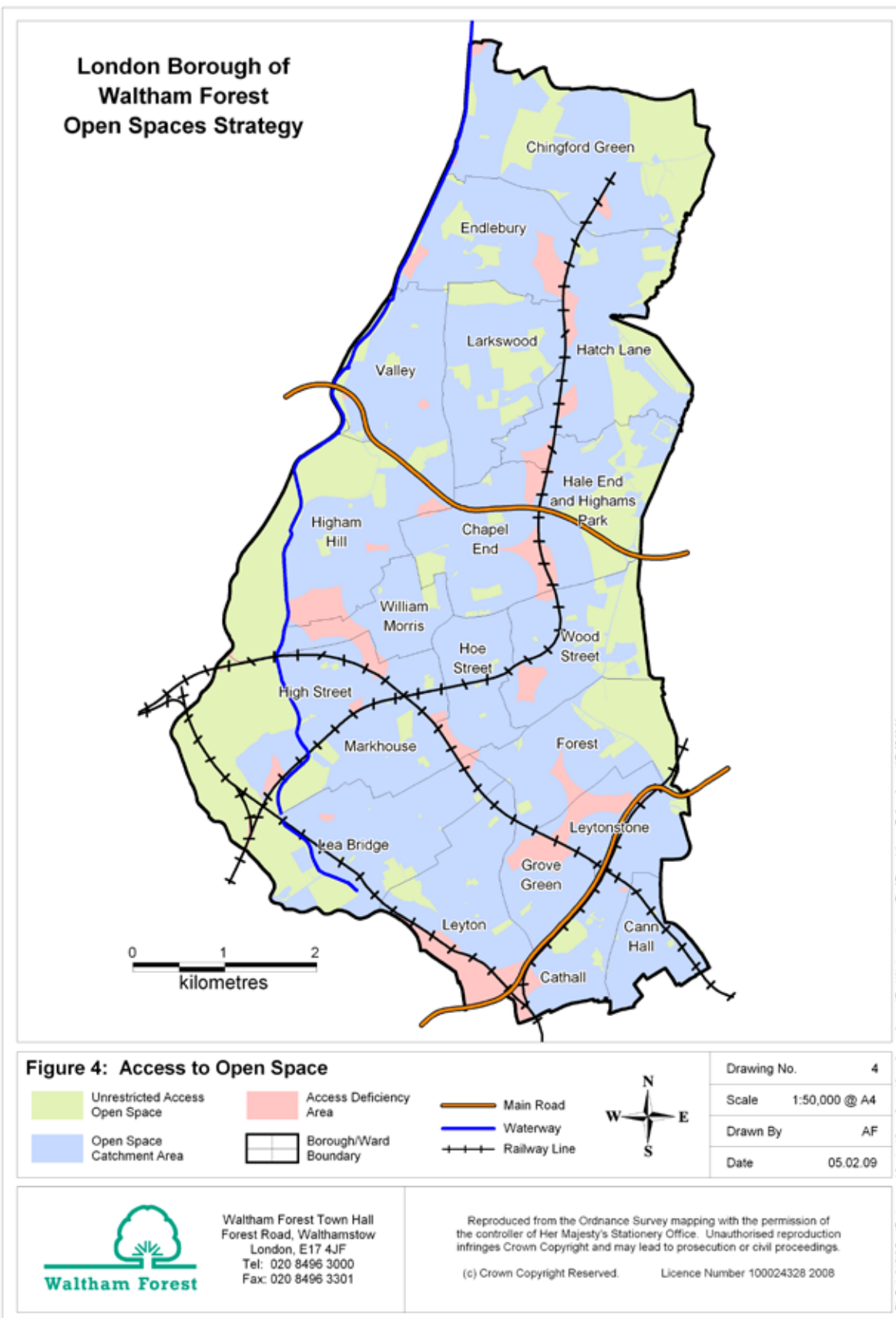
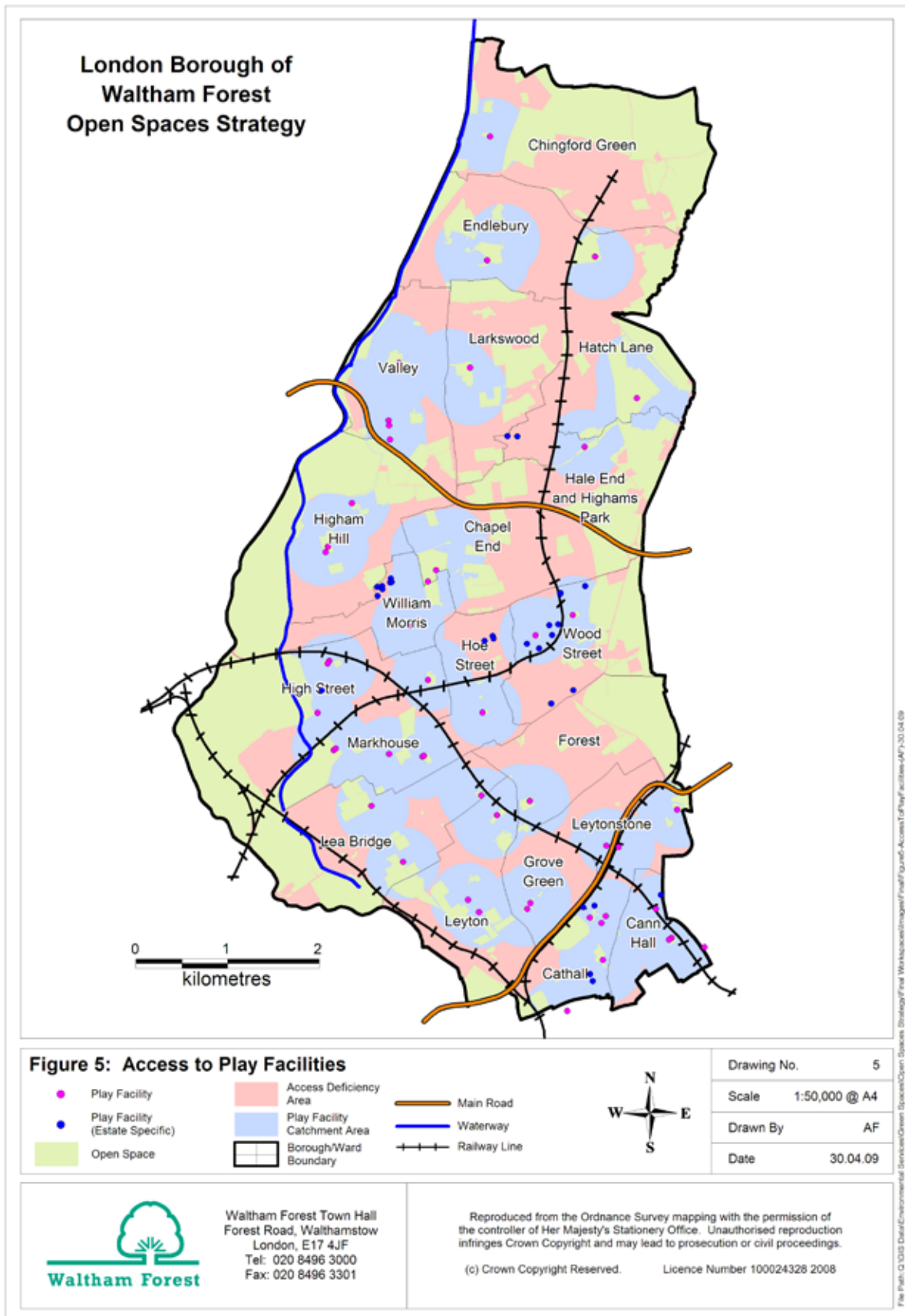


Figure 2.12 Access to local play facilities



While the borough offers a large number of allotments (approximately 2,200 plots provided over 38 sites) there is a substantial waiting list of over 800 people waiting for plots to become vacant.

How are open spaces being improved?

The borough has an Open Space Strategy with an action plan which outlines the borough's plans to improve open spaces.

1. Capital works

The following open spaces have had significant capital improvements in the last year:

- Lloyd Park – £5million restoration project, including new or improved sports and play facilities
- Abbots Park – refurbishment of tennis courts, pavilion and toilets
- Marsh Lane – new pavilion, pitches, plus improved access and nature conservation
- Wingfield – fencing around play equipment and improvements to area behind hut
- Cheyney Row – BMX track.

2. Communities projects

The following communities projects have been undertaken to enable/encourage users (with a focus on under-represented users) to benefit from their parks more:

- Audience Development Programme in Lloyd Park, including activities (running, sports, Tai Chi), targeted promotions, improved communications, increased staffing (to make the park feel safer) and volunteering programme
- Green Gym – a programme of nature conservation activities in parks, delivered to enable participants to improve their health
- Borough-wide activities – including Active Parks Month (targeting the over 50s), Love Parks Weeks (running variety of activities for families) and work with Friends Groups to develop improvement projects in parks.

3. Awards

Green Flags is a national award for parks of high quality:

- Green Flags achieved or retained for the following open spaces: Ridgeway Park, Coronation Gardens, Langthorne Park and Abbots Park
- Community Green Flag achieved for Hawkwood Nature Reserve.

3

**Wider factors
affecting health**

3.1 Socio-economic deprivation

Executive summary

Poverty and education are significant influences on health. According to the latest Indices of Deprivation (2010), Waltham Forest continues to experience increasing levels of deprivation with over a third of the population experiencing income deprivation. Around 11.4% of the population in the borough are long-term unemployed.²¹ Just under a third of the borough's children (30.4%) are considered to live in poverty based upon median household income.²² Around a quarter of all school children take free school meals. Rates of out-of-work benefit claimants, lone parent benefit claimants and Incapacity Benefit claimants are higher in the borough than the London average. Waltham Forest has moved from being the 47th most deprived local area in the UK in 2004, to 25th in 2007, to 15th in 2010. This is a relative measure and tells us how Waltham Forest compares to other boroughs. We have explored poverty in Waltham Forest further this year, looking in further depth at local population indicators to see what has changed in the borough.

Deprivation, income and employment as an Influence on Health

Deprivation and low income are significant influences on health, along with education. The relationship between health and low income exists across almost all health indicators.²³ The outcomes associated with low family socioeconomic status include higher risk of poor maternal nutrition, infant mortality, low birth weight, childhood injuries, child mortality, dental caries in children, malnutrition in children, infectious disease in children and adults, increased use of health care services chronic diseases in adulthood and earlier death. The risk associated with poverty is two-fold:

- People living in poverty are more likely to be exposed to conditions that are adverse for development (e.g. crowded or slum living conditions, unsafe neighbourhoods, etc)
- People living in poverty are also more likely to be negatively affected by these adverse conditions.

Measures of deprivation in Waltham Forest

The Indices of Deprivation (IMD) ranks for Waltham Forest have decreased over time from 47th in 2004, to 27th in 2007 and 15th in 2010, reflecting increasing relative deprivation. We have investigated whether these changes are due to relative effects, data effects, or actual absolute increases in deprivation. A significant increase in absolute deprivation in Waltham Forest is of interest to the borough as it will have implications for social and health inequalities in the borough and therefore policy and planning. The research finds that the IMD outputs are not suitable for measuring absolute change over time due to the methodology used and changes in data and denominators between the three IMDs. An exploration of alternative data sources available to Waltham Forest, the 2009 and 2011 population databases, show that between 2009–11 there has been an increase in the percentage of population living in households receiving means tested benefits and the percentage of population living in social housing tenure. This is indicative of a worsening of deprivation-related conditions in absolute terms. The recession, loss of employment in the economy in general and changes to benefits are undoubtedly linked to the increased percentages in these categories.

²¹ DWP, HM Revenue and Customs (HMRC) administrative data.

²² Public Health Outcomes Framework (PHOF).

²³ London Health Observatory: www.lho.org.uk/LHO_Topics/Health_Topics/Determinants_of_Health/Income.aspx

The impact of the recession on physical and mental health

The London Health Inequalities Network²⁴ commissioned UCL's Sir Michael Marmot to review the evidence of increased poverty on health and produce an indicator set for monitoring the short-, medium- and long-term effects of the recession on a range of outcomes. With regard to the potential impact on health, the most vulnerable groups – young people, older people, those already disadvantaged through poverty, lone parents and those with lower level skills and/or education – are most likely to be affected. Health inequalities, the gap between health outcomes for rich and poor, already wide in London – are expected to increase.

A set of potential indicators has been suggested to measure the impact. Whilst they won't be able to give a definitive picture they act as proxy measures. These include:

- Recorded self-harm and suicide
- Prescriptions for anti-depressants
- Cases of tuberculosis (exacerbated by poor housing conditions)
- Birth weight
- Measures of wellbeing (for example through local surveys).

An increase in risky behaviour – increased use of drink, drugs, smoking and gambling – is another potential outcome of the recession.

In addition to work already underway in the Local Authority to support people who are impacted by benefits changes and the impact on housing, the public health team is working with local authority departments to mitigate some of the impacts on health. This includes ensuring people are referred to stop smoking services, advice on gambling, advice on mental wellbeing, and helping pregnant women with advice on nutrition for babies and young children.

Children in poverty

There are a number of ways of measuring child poverty. In 2010, the proportion of children considered to live in poverty in Waltham Forest was 30.4%, marginally lower than the figure for 2009 of 32.7%. This figure is lower for London at 29.6% (30.8% in 2008) and nationally at 21.1% (21.3% in 2009). This is measured by the proportion of children living in households where income is less than 60% of national median household income.²⁵

As of May 2011 the number of children (0 to 18-year-olds) living in out-of-work benefit households in Waltham Forest was 16,460. This includes 14,500 children aged 0 to 15 years and 5,030 children aged 0 to 4 years.²⁶

The 2012 child poverty map estimates that 31% of children in the borough were living in poverty compared to UK figure of 21% (2011 data). Ranked by this measure across London and England Waltham Forest has the 15th and 26th highest percentage of children in poverty respectively.²⁷ This represents a slight improvement in the borough. In the 2011 child poverty map the respective estimated rates of child poverty for Waltham Forest and England were 35% and 21.3%. Note: In this figure, children are classified as being in poverty if they live in families in receipt of out of work benefits or in receipt of in-work tax credits where their reported income is less than 60% of median income (before housing costs).

²⁴ http://www.lho.org.uk/LHO_Topics/National_Lead_Areas/LHIN.aspx

²⁵ ChiMat – Child and Maternal Health Intelligence network.

²⁶ DWP, HM Revenue and Customs (HMRC) administrative data.

²⁷ Child Poverty Map of the UK. Campaign to End Child Poverty, January 2012.

Link to the latest news from the LGA on tackling child poverty

http://www.local.gov.uk/web/guest/education/-/journal_content/56/10161/2839745/ARTICLE-TEMPLATE

For more information on the Child Poverty Needs Assessment Toolkit please go to the following:

<http://www.idea.gov.uk/idk/core/page.do?pagelId=22025996>

<http://www.childpovertytoolkit.org.uk/>

Link to the Child Poverty Map of the UK report published by Campaign to End Child Poverty <http://endchildpoverty.org.uk/news/press-releases/child-poverty-map-of-the-uk-report-published-by-campaign-to-end-child-poverty/24/191>

Pupils receiving free school meals

In 2011/12, the number of pupils in receipt of free school meals in Waltham Forest was 6,291 (26.4%) in nursery and primary schools and 4,112 (27.1%) in secondary schools.

The London average for free school meal take-up in nursery and primary schools is lower at 25% whilst the national average is lower at 19.3%. Amongst secondary schools both the London and England averages for free school meal take-up are lower at 23.4% and 16.0% respectively.²⁸

What is the council doing to address child poverty?

Child Poverty Strategy and Needs Assessment

The Child Poverty Act 2010 placed a statutory obligation on local authorities to publish a needs assessment and child poverty strategy. Waltham Forest produced its Child Poverty Strategy in 2009, setting the Council's long-term strategic direction and the following key priorities:

1. Reduce the number of children living in workless households.
2. Reduce incidence of in-work poverty.
3. Getting young people off to the best possible start in their education – raising aspirations and closing the educational attainment gap whilst raising standards for all.
4. Reducing housing related poverty.
5. Work closely with partners to tackle the causes and effects of child poverty.

An action plan was developed against these priorities to establish the short-term operational direction of the strategy (2009–11). The changes to the political and economic landscape over the last two years have meant that it is necessary to refresh the strategy to reflect the current pressures in the borough and new priorities emerging from central government.

The child poverty needs assessment was refreshed in the summer of 2011, providing an updated evidence base and focusing increased attention on differences between wards, as much as regional and national differences. The needs assessment explored three elements of poverty:

- Mitigating the impact of poverty
- The movement out of poverty
- Breaking the cycle.

In terms of mitigating the impact of poverty, it was found that fragile family structure/resilience and low attainment and aspiration were the two new issues not previously addressed by the existing needs assessment. In terms of movement out of poverty, skills and training and sense of community were identified.

²⁸ DCSF School Census through London Datastore.

A new Cabinet Member for Child Poverty was appointed in June 2012 who will chair the Council's new child poverty board, which will lead on both the refresh of the child poverty strategy and its implementation.

Child Poverty Innovation Pilot Project

In 2009 the borough successfully bid for £1 million in funding from the Child Poverty Unit of the Department for Education to set-up 'More 4 U', a child poverty innovation pilot project²⁹.

More 4 U had four key outcomes:

- To increase parental employment and access to services
- Raise family income, including the improved take up of tax credits and benefit, including local authority administered benefits
- Build capacity of communities to tackle poverty
- Reduce intergenerational poverty by increasing educational attainment of vulnerable children, narrowing the gap.

The project provided holistic personalised support to families with children aged between 2 and 5 living in the catchment areas for five schools and children centres located in areas of high deprivation (Whitefield special school was also included). Running from March 2009 to March 2011, the project supported over 200 families; more than doubling the original target.

A review identified a number of wide-reaching findings, including that certain groups were more vulnerable to child poverty; including lone parents, families where either the child or primary carer had a disability or where the primary carer had a mental health issue.

Workless families

In 2012 Waltham Forest had 12,000 workless households, about 15% of households in the borough. Almost half of households were working (48%) and 36% were considered mixed households that have both working and workless members.

In total, about 24,500 people aged 16 to 64 and around 9,600 children (0 to 16-year-olds) live in workless households. This is equivalent to 14.0% of adults and 16.5% of children in the borough.³⁰

Benefit claimants

In November 2012, there were a total of 26,950 benefit claimants in Waltham Forest. This is the equivalent of 15.1% of the population aged 16 to 64. This compares with 13.3% in the London region and 13.8% in England.³¹

Out-of-work benefit claimants

The out-of-work benefit count combines several types of benefits related with worklessness. In June 2013, the out-of-work benefit count in Waltham Forest was 8,878 or 5.0% of the working-age population (aged 16 to 64). This compares with 3.6% of population claiming out-of-work benefits in the London region and 4.3% in England.³²

²⁹ The schools and children's centres used for the pilot scheme were Woodside Primary school and children centre; Downsell Primary School and Snowberry children centre; Barclay Primary school and children's centre; Sybourn Primary school and children's centre; South Grove Primary School and Low Hall children's centre.

³⁰ Annual Population Survey (APS).

³¹ Working Age Client Group, DWP through Nomis.

³² Working Age Client Group, DWP through Nomis.

Lone parent benefit claimants

In November 2012, the percentage of lone parent benefit claimants in Waltham Forest was 1.7% of all people aged 16 to 64, compared with 1.6% in London and 1.3% in England. In total there were 2,970 lone parent benefit claimants in the borough in November 2012.³³

Incapacity Benefit claimants

In November 2012, the total number of incapacity benefit claimants in Waltham Forest was 10,340. This is equivalent to 5.8% of working-age population and compares with the London average of 5.6% and national average of 6.0%.³⁴

Potential impacts of Universal Credit

The creation of Universal Credit in place of other separate benefits is going to be fully introduced from April 2013. Jobseeker's allowance, Child Tax Benefit, Housing Benefit, Income Support and income related Employment Support Allowance will be merged Universal Credit. Whilst the idea is to simplify benefits payments to ensure that everyone is financially better off by working than not, there is much debate as to whether or not this move will further impoverish certain households in London.

Recent research from London councils on the early impacts of the reforms to Housing Benefit (including the cap of a maximum of £20,800 a year for families in four bedroomed houses) has shown that landlords in London are three times more likely to evict tenants or not renew tenancy agreements than they are to lower rents. In addition, 17% of London landlords said they would no longer let their property to Housing Benefit claimants as a direct result of Housing Benefit reforms compared to 9% nationally.

In 2010 only six London boroughs have lower median average rents for a three bedroomed property than Waltham Forest where the median average weekly rent was £253. Across London the lower quartile was also £253 whilst the median average was £287 and the upper quartile £376. There is therefore a risk that structural changes in the housing market could push people out of more expensive parts of London to move to cheaper areas.

A 2011 report from the Centre for Economic and Social Inclusion also claimed that some of those moving into low paid work would be worse off under Universal Credit. It suggests that a London lone parent with two children moving to a full-time job on minimum wage and using childcare will be £5,000 a year worse off.³⁵

For more information see:

London Councils research:

<http://www.londoncouncils.gov.uk/news/current/pressdetail.htm?pk=1491&showpage=-1>

Centre for Economic and Social inclusion:

http://www.cesi.org.uk/sites/default/files/publications/CESI_making_work_pay_in_London_universal_credit_0.pdf

³³ Working Age Client Group, DWP through Nomis.

³⁴ Working Age Client Group, DWP through Nomis.

³⁵ GLA London map of income, tax, house prices and rent (originally sourced from the Valuation Office Agency).

3.2 The built environment – spatial planning and health

Executive summary

Good use of spatial planning offers opportunities to change the environment in which people make choices about their health, making it easier to choose the healthy option. The London Borough of Waltham Forest Spatial Planning Department and Public Health have formed an effective partnership to identify and implement these opportunities.

What is spatial planning?

Spatial planning is a process of place shaping and delivery. It aims to:

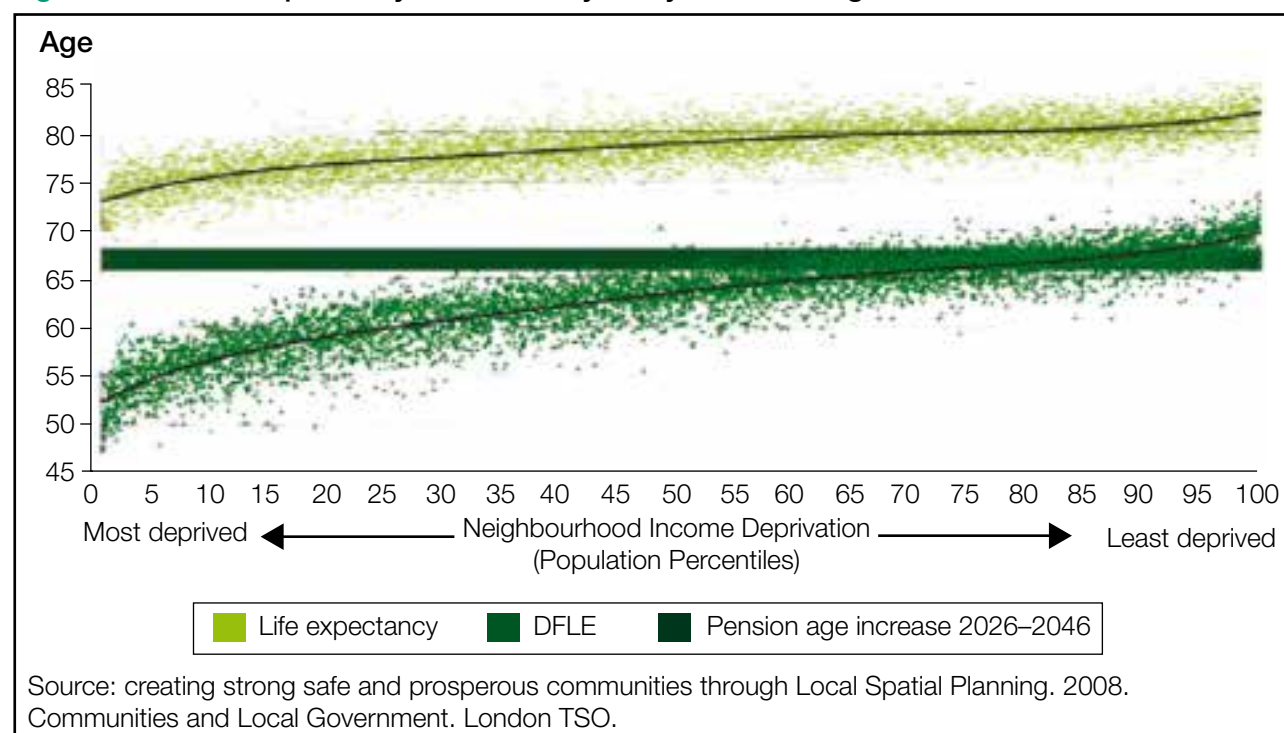
- produce a vision for the future of places that responds to the local challenges and opportunities, and is based on evidence, a sense of local distinctiveness and community derived objectives, within the overall framework of national policy and regional strategies
- translate this vision into a set of priorities, programmes, policies, and land allocations together with the public sector resources to deliver them
- create a framework for private investment and regeneration that promotes economic, environmental and social wellbeing for the area
- co-ordinate and deliver the public sector components of this vision with other agencies and processes [e.g. Local Area Agreements (LAAs)]
- create a positive framework for action on climate change
- contribute to the achievement of sustainable development.

Links between spatial planning and health include:

- High quality healthy environment is unlikely to emerge spontaneously and integrated decision making across a range of service areas is more likely to deliver real outcomes. Planning provides the opportunity through joined up actions to address some of the behavioural, social and environmental factors linked with health
- As part of the remit of spatial planning, policy measures as different as they may be on housing, transport, economy, industry and commerce, built and natural environment, waste, pollution, water and energy must now take health into account
- Planning decisions made through a spatial planning approach has greater capacity not only to overtly change environments, but also to create new environments which encourage people to lead healthier lives.

The Marmot Review of Health Inequalities in England in 2010 found that health inequalities that are preventable are unfair. There is a clear social gradient for mortality and morbidity where the poorer are sicker and die earlier. Mortality and morbidity, along with life expectancy and disability free life expectancy are influenced by the conditions in which one is born, lives and dies. The top curve in the graph in Figure 3.1 shows the relationship between neighbourhood income and life expectancy. The bottom curve shows the gradient in disability free life expectancy. The average difference between the richest and poorest neighbourhoods is 17 years. The social gradient in health means that everyone below the highest suffers some health inequality.

Figure 3.1 Life expectancy and disability free years and neighbourhood income



The Marmot Report identified a convergence in policies aimed at improving health and wellbeing with those designed to advance sustainability and address climate change. For example, a well designed public realm with high quality green open space will encourage physical exercise, improve mental health, increase biodiversity and help to mitigate the urban heat island effect. The case for delivering improvements to health and wellbeing through spatial planning policy should therefore be seen as part of the wider case for delivering sustainable communities.

Links between spatial planning and health date from rapid urbanisation in the nineteenth century, which created health and social problems that led to the passage of legislation promoting sanitary and healthy living conditions. As the burden of ill-health moved from communicable diseases to chronic diseases associated with unhealthy lifestyles in the twentieth century, attention moved away from the built environment to individual behaviours. However, there is now strong evidence that the built environment continues to shape health outcomes. This is reflected in England in national plans to transition public health professionals back to local authorities.

Evidence of effective interventions

Evidence is good for integrated appraisal in one statutory process including health, social and environmental considerations, with involvement through the whole plan, policy or project process, so that health objectives are integrated into the thinking from the outset.

The NHS London's Healthy Urban Development Unit planning development tool provides one effective approach. Integrating health into spatial planning is cost-effective. It needs to happen through consultation with communities. There are potentially very large gains to be obtained from effective integration of health and planning for whole-town infrastructure for walking and cycling and the retrofit of home zones that will often far outweigh the cost of incorporating health considerations early in the planning process.

Linking spatial planning into the JSNA process contributes to securing the long-term wellbeing of communities. JSNAs to produce more location-specific profiles should enable a more targeted approach to planning interventions to help improve local health and wellbeing for issues such as access to quality primary care services, but also for issues such as access to fresh food, reducing obesity, and health links to deprivation, air and noise pollution.

The largest opportunity to make a difference in improving the health and wellbeing of people and communities lies at the local and neighbourhood (and ward) levels. The Sustainable Community Strategy will continue to play a crucial role in a corporate approach to local area planning. The local spatial planning approach, with its suite of planning documents, will continue to underpin the bringing together of different services to support integrated planning for places and spaces through the process of infrastructure planning and delivery.

At the development level, decisions made on individual development proposals support the delivery of key priorities and outcomes. The development management process offers opportunities for both the JSNA as health evidence and local NHS organisations to be influential in the outcome of decisions. Examples of opportunities include in the master planning process, pre-application discussions, consultation on planning applications, and playing a role in delivery and implementation.

One study showed that in areas in England with more green spaces the gradient in deaths from circulatory disease by income deprivation is reduced. This suggests that the amount and the distribution of green space have great potential to reduce health inequalities.

There is strong evidence that spatial planning for open space that is safe and easy to get to increases the amount that people exercise and that it improves mental health

Local Initiatives

Public Health and Spatial Planning at the London Borough of Waltham Forest worked in 2011/12 to embed health policy in the local authority Core Strategy, including:

- Policy CS13 – promoting health and wellbeing, improving access to health facilities, promoting higher levels of regular exercise, reducing the proliferation of any land use which reduces people's ability to be healthy
- Policy CS2 – improving housing quality and choice, seeks to ensure that residents live in high quality, well designed homes
- Policy CS4 – maximising opportunities to deliver new and improved health services and facilities
- Policy CS16 – providing more attractive and safer environments.

and in the Development Management Policies:

- Policy DM25 – Ensures new development meet high environmental standards and minimises the various forms of pollution within the borough
- Policy DM24 – Supports major applications with positive health impacts on the health and wellbeing of communities demonstrated through the use of Health Impact Assessments (HIA). Resisting hot food takeaways where it results in over concentration of such uses in town centres and where they are located in close proximity (within 400m) of a school, park or youth facility outside of town centres.

Policy DM7 – Seeks to ensure that all new residential development is of the highest quality both internally and externally by setting out minimum internal and external amenity space standards.

Since the Core Strategy was drafted, public health has provided evidence on health concerns of a fast food takeaway and a betting shop.

Supplementary planning documents (SPD)

In 2007, Waltham Forest was the first local authority to establish an SPD to manage hot food takeaways near schools to ensure residents have choice in range of food including healthy food options.

Proposed projects to improve public access to nature and increased opportunities for physical activities include Walthamstow Wetlands, Lee Valley Regional Park and Epping Forest improvements.

Evidence of effectiveness

Since introduction of the SPD for hot food takeaways in Waltham Forest, 33 planning applications for hot food takeaways have been refused planning permission. The Council has successfully upheld planning appeals. There has been increased planning enforcement action. There has been a reduction of 47 hot food takeaways from 241 in 2009 and 194 in 2011 on Waltham Forest's Food Premises Register.

Planning applications are being considered on their full merits including the impact on health outcomes – such as related to air/noise pollution, access to open/amenity spaces, community safety, climate change, access to social infrastructure, highway and traffic safety, and employment implications.

The application of good urban design practices including the provision of adequate internal and external spaces is intended to create healthier living environments. Relevant local development framework policies being implemented include enhancing the green infrastructure network, improve walkability, provide safe pedestrian friendly streets to encourage people to walk and cycle more for local shopping, school trips and leisure purposes thereby improving rates of physical exercise.

Public perspective

A public consultation took place regarding the Hot Food Takeaway SPD and 304 responses were received. Of the total responses 88.8% of respondents supported the proposed SPD to limit hot food takeaways around schools.

Analysis of the responses included the following specific comments relating to the management of hot food takeaway shops in Waltham Forest:

- 56% of respondents identified health (i.e. childhood obesity, proximity to schools and food quality)
- 56% of respondents identified litter
- 43% of respondents identified proliferation of outlets
- 10% of respondents identified anti-social behaviour or crime
- 9% of respondents specifically identified lack of retail diversity
- 6.7% of respondents identified road safety
- 6% of respondents specifically identified visual amenity.

Priorities for the next five years

- Within regeneration projects include initiatives that will aid in improving the healthiness of the surrounding area, aligning with the borough's 'Better High Streets' campaign and the Waltham Forest Creating the Place for a Good Life health and wellbeing strategy. Projects could include improving the quality of takeaway food and promoting responsible pubs to encourage safe drinking
- Test the draft Health Impact Assessment template on the developing housing strategy and embed into existing assessment processes in the local authority
- Expand access to green space.

Prioritise policies and interventions that both reduce health inequalities and mitigate climate change, by:

- improving active travel across the social gradient
- improving good quality open and green spaces across the social gradient
- improving the quality of food in local areas across the social gradient
- improving the energy efficiency of housing across the social gradient.

Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.

Examine the potential to redefine food safety standards to reflect current threats to health and use food safety workforce to promote issues around healthy issues such as eating.

Raise the profile of work within the Council for joint working between spatial planning and public health to consolidate and expand areas of partnership, to develop healthy policies including food provision, betting shops, tobacco and shisha outlets and alcohol outlets, for example.

Support locally developed and evidence-based community regeneration programmes that:

- use spatial planning to remove barriers to community participation and action and reduce social isolation
- link JSNA and other assessment tools to develop a fuller understanding of areas.

Use **Healthy Places** resource, an online tool put together by a team from the National Heart Forum. This tool highlights how local authorities can use existing laws 'that have the potential to change local environments and encourage more active lifestyles and better diets'.

Develop Table 3.1 with local examples of improving health outcomes through local planning.

Table 3.1 Supporting health outcomes through local planning documents

Potential applications	JSNA core dataset contribution	Examples
Core Strategy DPD – Overall vision, strategic objectives for the area, a delivery strategy for achieving these objectives with locations for strategic development indicated on a key diagram; and arrangements for managing and monitoring delivery.		
<ul style="list-style-type: none"> • Future reviews 	Demography, socio-environmental, services	Brent (2010) Wakefield (2009)
Development Control DPD – Topic-based policies and criteria against which planning applications for the development and use of land and buildings will be considered.		
<ul style="list-style-type: none"> • Standards of provision relating to a range of land uses • Assessment requirements for design and sustainability 	Socio-environmental context, burdens of ill-health, access to health services, behaviour	South Cambridgeshire (2007) Brent (Preferred Option) Richmond (Pre-submission)

Potential applications	JSNA core dataset contribution	Examples
Area Action Plan DPD – Planning framework for areas/neighbourhoods where significant change with a focus on implementation.		
<ul style="list-style-type: none">• Deliver planned growth areas• Stimulate regeneration• Protect areas• Focus the delivery of area-based regeneration initiatives	Demography, local area, socio-environmental context, employment, burdens of ill-health, access to health services, access to health services, behaviour, user perspectives	Central Wakefield (2009)
Supplementary Planning Documents – Local planning authorities and other bodies to provide greater detail on the policies in development plan documents.		
<ul style="list-style-type: none">• Design standards	Demography, living arrangements, economic, transport, burdens of ill-health, behaviour	Salford (2008) Corby (2009)
<ul style="list-style-type: none">• Planning obligations		Milton Keynes (2005) Sandwell (2009)
<ul style="list-style-type: none">• Fast food takeaways		Waltham Forest (2009) Salford (2007)
Statements of Community Involvement – Identify and explain the process and methods for community and delivery stakeholder involvement through the different stages of plan preparation, including in pre-application and planning obligations.		
<ul style="list-style-type: none">• Future reviews	Demography, user perspectives	North Somerset (2007)

Source: The Marmot Review: implications for Spatial Planning. The Marmot Review Team. Report authors: Ilaria Geddes, Jessica Allen, Matilda Allen, Lucy Morrissey.

3.3 Housing

Executive summary

The shortage of housing across London means that concerns about finding decent, affordable housing is no longer confined to those residents who are on low incomes. An increasing number of middle income households are struggling to find suitable accommodation in the borough and are finding that their desire to own their own home is becoming increasingly out of their reach.

One of the most important changes which has occurred in Waltham Forest in recent years is the change in housing tenure. In 2012, the privately rented sector made up 32% of all residential dwellings, a sharp rise from 18% of all dwellings in the 2001 Census with a matching drop in owner occupation. This is reflected in 19% of all dwellings on the borough being either a House in Multiple Occupation or a converted property.

Table 3.2 Tenure proportions 2011 House Condition Survey

Tenure	Dwellings	Per cent
Owner occupied	45,090	46%
Privately rented	31,810	32%
Housing association (RP)	10,860	11%
Local authority	10,420	11%
All tenures	98,180	100%

A Housing Needs Survey carried out in 2012 estimated that 11% of all dwellings in the borough are overcrowded, with this figure being 17.6% in the private rented sector. The dwelling stock in Waltham Forest appears to be being used very intensively with rooms other than those designed as bedrooms being used for sleeping, particularly in the private rented sector.

Across Waltham Forest, it is estimated that 28% of households are unsuitably housed. Unsuitable housing covers a wide range of categories such as overcrowding, stock condition, support needs and affordability.

The Housing Needs Survey profiled the housing requirements for Waltham Forest between 2010–31 and found that new homes were required across all tenures:

Table 3.3 2010–31 Housing requirements for Waltham Forest

Tenure and Size	Market housing	Intermediate housing	Social rented housing
1 bedroom	600	1,700	2,300
2 bedrooms	850	2,350	2,050
3 bedrooms	1,200	1,500	2,650
4+ bedrooms	250	150	300
Sub-total	2,900	5,700	7,300

There are currently over 26,000 households registered on the Council's housing register with approximately 60% of these households in receipt of Housing Benefit. 10% of people on the waiting list are people who are tenants of the Council who need to move for a variety of reason including overcrowding (households), health problems, or social issues such as domestic violence or harassment.

In 2012/13, Waltham Forest accepted a full housing duty to 1,045 homeless households, compared to 600 in 2011/12 and 311 in 2010/11. While this most recent rise is linked to local administrative issues which are being resolved by restructuring, the underlying trend is increasing, with a predicted 850 acceptances for 2013/14.

The vast majority of homeless people are not rough sleepers. The most recent work identified 15 rough sleepers in the borough in autumn 2012.

Housing as an influence on health

Housing quality is an important determinant of health and a marker for poverty. The condition of the housing stock is a major influence on the borough's capacity to reduce inequality. Factors that create risks to health include the presence of lead, asbestos, radon, house dust mites, cockroaches and other infestations; extreme low or high temperatures and inadequate ventilation, inferior air quality, dampness/mould, cramped conditions and multiple family occupancy, among others. Health outcomes that may result from these conditions include asthma and Tuberculosis.

Housing stock by tenure

In the 2011 Census the number of dwellings in Waltham Forest was 98,000 of which 77% were in the private sector (owner occupied or private rented). Social and affordable housing accounted for 22% of dwellings, about half of which (10,365) belong to the local authority and the other half (11,000) owned and managed by Registered Providers (RPs). RPs are also sometimes called Housing Associations.

Data from the 2011 Census shows that around 50% of households in the borough are owner occupied (either owned outright or with a mortgage or loan). Just over a fifth of dwellings in the borough are social housing (22%).

The Greater London Authority (GLA) analysis of Annual Population Survey data shows that between 2004 and 2009 home ownership fell from 60% to 49% in Waltham Forest. This is a bigger fall than in London and the UK in the same time, where home ownership fell by four percentage points from 2004 to 2009. According to the 2011 Census of all households in Waltham Forest, 20% own their home outright and 30% have a mortgage or loan.

Approximately 36% of the residents are of white British origin although the percentage of residents from all white origins is 52.1% which may be attributable to the large influx of Eastern Europeans into the borough since 2004. Waltham Forest has the second highest percentage (9%) across London of residents from EU accession countries. The percentage of residents from all BAME categories for 2011 is around 48%, with 10.2% of residents being of Pakistani origin.

The importance of the private sector in meeting housing need is greater than it has ever been. Since 2001, the private rented sector has almost doubled, from 18 per cent in 2001 to 32 per cent of the housing stock in 2011. Continuing pressure on the social rented sector, changes in the homelessness duty and the impact of welfare reform including housing benefit changes mean that we are increasingly dependent on the private sector to meet housing need. As well as working with RPs to maximise the supply of social and affordable housing, we need to build links with private sector providers to increase supply and improve conditions in this sector, as well as reducing the number of empty properties.

Sources: Department for Communities and Local Government; 2001 Census; Focus on London 2011: Housing: A Growing City. GLA/2011 Waltham Forest Housing Needs Survey and Strategic Housing Market Assessment.

What the council is doing

Private housing

- Waltham Forest operates a property accreditation scheme to help landlords and tenants in the private sector. The process involves officers working in partnership with landlords to ensure their properties are safe, secure and sanitary. Unlike other accreditation schemes that assume all of a landlord's properties are up to a certain standard, this new scheme assesses and accredits each property individually. The Council also works in partnership with other London Boroughs on the London Landlord Accreditation Scheme which formally recognises 'good landlords' who provide tenants with good quality and safe accommodation
- Houses in Multiple Occupation (HMO): As part of the Housing Act 2004 legislation, mandatory licensing has been introduced for all houses in multiple occupation that are:
 - Of three storeys or more
 - With five or more tenants (including children)
 - Belonging to two or more households.

To obtain a licence, HMOs need to have adequate facilities, including safety and sanitation, and sufficient space for the number of people intended for housing. Licensing of HMOs is carried out by the Waltham Forest Housing Standards team. Waltham Forest currently only have mandatory licensing scheme for high risk HMOs (as described above) but may expand this to other types of properties, or to a specific area, in the future.

Compulsory licensing for all landlords

The Council wishes to introduce a compulsory licensing scheme and is currently consulting on this proposal. If compulsory licensing is introduced, landlords would have to apply for a licence from the Council if they want to rent out a home in the borough. The Council has found a clear link between the private sector and antisocial behaviour. Compulsory licensing will deal with this as well as improving poor housing standards in all private rented accommodation.

- Waltham Forest is working with the East London Housing Partnership and local agencies to offer help and advice on equity release, financial advice through specialist agencies and advice on home maintenance
- Waltham Forest has commissioned a Home Improvement Agency Services to vulnerable residents which acts as a one-stop-shop where older (65+), disabled and low-income families can go to for advice and support with a wide-range of housing related issues. This service is funded through Supporting People. The service includes support to apply for funding for adaptations and repairs, handy person services for small jobs around the home and garden, welfare benefit checks and support to apply for grants for central heating/boilers to make homes more energy efficient

- Waltham Forest recently set up a private sector landlord forum for landlords and agents who work with or want to work with the council; The Council will continue to develop this forum and use it to ensure that we take the views of local landlords and agents on board in all aspects of work with the private sector
- Where private tenants are found to be living in unsatisfactory accommodation, the Council will continue to use statutory inspection and enforcement powers (in accordance with the Housing Act 2004) which will be directed to achieving desirable improvements.

Social housing

- The Council has been very proactive in encouraging the development of new homes in the borough. By the end of August 2013, Waltham Forest had 2,950 homes which have already received planning permissions and are in the housing supply pipeline, with planning applications for a further 1,200 units.

The Council has commissioned a stock review consisting of a series of options appraisals to cover sheltered housing stock, hostels, out of borough stock and a number of estates requiring significant works to bring them up to an appropriate standard. Marlowe Road and Montague Road Estates were identified as one of the highest priorities for the Council in terms of needing improvements. In July 2013, the Council agreed a multi-million pound regeneration scheme to transform the Marlowe Road Estate and create a thriving mixed community. This will involve demolishing part of the existing estate and building 150 new, high quality Council homes for existing tenants and around 236 new private homes. The Council is currently working with a Resident Procurement Group to develop these proposals and select a developer partner who will be chosen by April 2014.

Fred Wigg and John Walsh Towers on Montague Road Estate are also in line for a multi-million pound improvement programme. The scheme is at a very early stage but we are already consulting with residents with the aim of creating quality homes.

In 2010, the Council was successful in obtaining funding from the Homes and Communities Agency to build its own affordable homes under the local authority New Build programme. A total of 22 homes have been built on two sites at Holland Mews and Albany Road. This is the first time the local authority has built new homes in over 20 years.

Waltham Forest's Garage Strategy was approved by the Council's Cabinet in November 2011. The Strategy involved identifying dilapidated garage sites in the borough, which were an eyesore and attracted antisocial behaviour. So far, the Council has created 109 new homes for affordable rent from these garage sites which has provided much needed housing for 520 people, with a further 23 sites already identified. The Council plans to do more of this and are actively looking for similar sites to make the best use of existing land:

- Through the site disposals programme the Council has identified a number of sites in its ownership capable of supporting housing development. These sites will be disposed of through the most appropriate mechanisms according to the characteristics of the site and potential for development
- Working jointly with the Council, Ascham Homes has recently completed a project to install solar photo-voltaic (PV) panels to 975 Council dwellings across the borough. The panels provide tenants with an amount of free electricity which reduces their fuel bills. In addition, the Council receives an income at an agreed rate for all electricity generated by the panels, plus a further payment for the excess electricity not used by tenants. Investment in solar PV systems is popular because it offers benefits to tenants and a long-term financial return to the Council
- The Council will continue to work closely with local Registered Providers and will support them in developing positive housing management policies, including tackling tenancy fraud, engaging young people, promoting training and employment opportunities and reducing anti-social behaviour.

Housing waiting list

People with support needs

According to the 2011 Waltham Forest Housing Needs Survey, 19,300 households in Waltham Forest contained at least one person with health problems. This represents around 20% of all households. It should be noted that some of the households contained more than one individual with health issues. The main problems identified were conditions that substantially limit one or more physical functions, and mental health problems.

The same survey reveals that around 5,600 households include members who need some form of care or support. Around 6,000 households reported that the health problem affected the housing requirements of their household. Of these households, over half (54%) rent from a social landlord while around 42% own their own home and are therefore responsible for their own adaptations. Given that many of these households will have relatively low incomes, the affordability of adaptations can be a problem.

Of those who do have special housing requirements, 52% felt that their requirements were already met by their current home, which implies that 48% of households felt that their homes were not adequately adjusted to the health problems of household members. This represents around 3% (2,800) of all households in Waltham Forest. Of this group 48% thought that their current home could be adapted to meet their needs; 43% felt that they would need to move to another home which was more suitable for their needs. Therefore, there are currently around 1,400 households in Waltham Forest who require adaptation in their current homes and 1,200 who need to move to another home, split approximately equally between the private and social sector.³⁶

What the Council is doing

- The restructuring of the Housing Solutions Team in 2013 focuses on delivering a holistic service to housing clients. The group includes a team addressing the housing needs of 16 and 17-year-olds, and priorities include dealing with mental health issues and promoting sexual health and another that supports vulnerable, homeless households in temporary accommodation
- A further team within the group is tasked with achieving the Council's priority of reducing by 50% the number of people on the waiting list living in overcrowded conditions, including those in private and social housing
- Where broader problems, including health issues, are identified by any of the teams, council officers work in liaison with other partners such as Age UK, health services, fire service (for fire safety advice) and education services to address these issues in a holistic manner. Links are also being made with GPs, health visitors and Children's Centres to promote joint working in this area
- As part of the Government's Welfare Reform programme, social tenants who are under-occupying (i.e. have more bedrooms than their statutory requirement) have had their housing benefit cut from April 2013. The Council is therefore targeting this group to encourage them to seek alternative options in order to reduce the risk of them being unable to pay their rent
- In order to ensure that properties are allocated in a way that meets the needs of disabled people, the Council operates an Accessible Housing Register integrated into the Choice Based Lettings scheme
- Waltham Forest works with our housing partners to ensure that adapted properties are advertised for allocation at the earliest stage to enable developers to tailor the properties to the needs of their future residents wherever possible.

³⁶ 2011 Waltham Forest Housing Needs Survey and Strategic Housing Market Assessment.

Housing market and housing costs

Prices and affordability – Housing in Waltham Forest, like all London boroughs, is characterised by high prices relative to national levels, a shortfall of accommodation across all tenures, and high development costs. The average rental price in August 2013 was £885 per month for a one bedroom property, and £1,390 per month for a three bedroom property. £1,390 per month for a three bedroom property (Source: Zoopla). The Royal Institute of Chartered Surveyors (Rics) is predicting that the cost of renting a home in 2013 will rise by four per cent as demand for limited housing stock increases as first-time buyers are still frozen out of the property market.

In 2012/13, most property sales in Waltham Forest involved terraced properties which sold for on average £281,961. Flats sold for an average price of £183,754, while semi-detached properties fetched £337,436. The most expensive area within Waltham Forest was Oakhill (£358,013) and the least expensive was Leyton Marshes (£212,399). During the last year, sold prices in Waltham Forest were 3% up on the previous year and 4% up on 2007 when the average house price was £245,632. Average house price was £245,632 (Source: Rightmove).

In the 2011 Census, the median gross pay for full-time workers living in Waltham Forest was stated to be £541 per week which makes buying or renting even the lowest price home unaffordable for people on median pay based on housing costs (i.e. rent/mortgage and service charges) being no more than 33% of income. There are also an increasing number of middle income residents who would have traditionally been first time buyers but who now have no realistic prospect of owning their own home.

Welfare reform and the Benefits Cap has made any home in Waltham Forest potentially unaffordable for the largest families unless they are working.

Homelessness and rough sleepers

Local Housing Authorities have a duty to provide advice and assistance about homelessness and the prevention of homelessness to anyone in their district, and in addition they must provide accommodation if there is reason to believe that an applicant may be eligible, homeless and in priority need, while a full assessment is carried out. If the local authority is satisfied that the applicant is eligible, unintentionally homeless and in priority need, then it has a duty to secure longer term accommodation for the applicant.

The 'priority need groups' include households with dependent children or a pregnant woman and people who are vulnerable in some way e.g. because of mental illness or physical disability.

Who is homeless?

- 58% of homeless acceptances in 2012/13 were in the 25 to 44 age group, with 29% being under 25
- 18% were from white British backgrounds (compared with 36% of the whole borough population), with 14% from other white backgrounds and 62% from other BAME backgrounds (compared to 48% of the whole borough population). 6% did not state their ethnicity
- 83% had priority need because they had dependent children or were pregnant, 7% because of physical disability and 4.7% because of mental illness or disability
- The vast majority of homeless people are not rough sleepers. The most recent work identified 15 rough sleepers in the borough in autumn 2012.

Why are people homeless?

The main causes of homelessness in Waltham Forest are loss of private rented accommodation and eviction by friends and family. The proportion of those becoming homeless as a result of losing privately rented accommodation is on the increase:

- In 2012/13, 37% of accepted households had lost private rented accommodation, compared with 26% in 2011/12
- A further 37% had become homeless as a result of friends or family not being able to accommodate them, a slight decrease from 42% in 2011/12
- People becoming homeless due to domestic violence fell from 8% to 5%.

Rough sleepers are people sleeping, about to bed down or actually bedded down in the open air, in buildings or other places not designed for habitation. The estimated number of rough sleepers in Waltham Forest is currently 15.

What the Council is doing:

The Council has developed a Homelessness Strategy 2013–18 which takes account of new legislation and the overall changing landscape that has developed since the previous Homelessness Strategy, particularly the impacts of welfare reform and the Localism Act 2011 which now allows local authorities to discharge their homelessness duties by offering accommodation in the private sector.

Following the review, four key objectives have been identified that form the basis of the Homelessness Strategy 2013–18 which will be delivered in the following ways:

(a) Preventing homelessness and promoting alternative housing solutions

Some of ideas for delivering this include:

- Keeping people in their existing home by visiting applicants in own home at an early stage and working with landlords for a planned move if eventual eviction is inevitable
- Encouraging residents to contact us as early as possible by raising awareness of the Housing Solutions Team, and carrying out 'mythbusting' campaigns about waiting times and promoting that the private sector is often used to discharge the Council's homelessness obligation
- Partnership working for people at risk of homelessness including working with external agencies to help young people leaving care, victims of domestic violence and single homeless people.

(b) Developing a response to the Government's programme of welfare reform

Some of ideas for delivering this include:

- Partnership working and sharing good practice by working with others such as Jobcentre Plus, the Credit Union and Citizens Advice Bureau to help people get jobs, develop money management skills and receive debt advice
- Reviewing policies such as the allocations scheme, the Local Plan and the tenants 'incentive to move' scheme to ensure we are making the best use of properties in the borough.

(c) Providing appropriate accommodation and support for homeless households

Some of ideas for delivering this include:

- Ensuring a supply of suitable temporary accommodation by reviewing how accommodation is procured and where households are placed
- Increasing private sector option for homeless households by developing initiatives to encourage more property owners to give properties over to Waltham Forest Lettings
- Supporting vulnerable households when they are in temporary accommodation and when moving into long-term accommodation to prevent repeat homelessness.

(d) Supporting vulnerable people

Some of ideas for delivering this include:

- **Linking with Supporting People priorities** by providing targeted support for those with physical and mental health problems with a particular focus on groups identified as priority groups within the Supporting People
- **Insisting on lifetime homes for new build properties** so that properties can be readily adapted if a tenants' circumstances change which prevent homelessness
- **Preventing continued rough sleeping** by working with agencies like London Street Rescue and providing targeted support where necessary.

An action plan has been developed for 2013–15 with a commitment to develop annual action plans until 2018.

3.4 Crime

Executive summary

Recorded crimes decreased by 6% between 2012/13 and 2013/14. Data up to the end of March 2014 show that Waltham Forest has the 13th highest rate of crime (out of 32 boroughs) within the Metropolitan Police Service (MPS), in line with the MPS average.³⁷

The analysis of community safety issues in Waltham Forest was undertaken with a problem-oriented approach. That is to identify the most 'risky people' i.e. those most victimised and those responsible for committing most crime in the borough; and the most 'risky places', the areas with the greatest community safety issues.

A review of performance, undertaken to address the priorities agreed from the last strategic assessment, showed that although there have been some significant improvements culminating in an overall reduction in crime. Work still needs to be undertaken to ensure that projects are evaluated appropriately and that effective governance arrangements are in place.

SafetyNet

The Crime and Disorder Act 1998 was introduced to promote the practice of partnership working to reduce crime and disorder, placing a statutory duty on police and local authorities to develop and implement a strategy to tackle local problems. The responsible authorities are required to work in partnership with a range of other local, public (including the NHS), private, community and voluntary groups and with the community itself.

Section 5 of the Act imposes a duty on local authorities and the police in England to establish Community Safety Partnerships (CSPs) in their local areas. The CSP in Waltham Forest is known locally as SafetyNet and is the key vehicle for tackling crime, disorder and substance misuse issues in this borough. The development of CSPs recognises that both the causes of crime and disorder and the interventions required delivering for safer, more secure communities lie with a range of organisations, groups and individuals working in partnership. Crime reduction is not solely the responsibility of the police.

Crime in Waltham Forest

From April 2013 to March 2014 there were 21,958 recorded crimes in Waltham Forest compared to 23,452 for the previous year; a 6% decrease in crime, or 1,494 less offences.

Waltham Forest has made progress in moving towards the MPS average over the last 6 months of 2013/14 and broadly matches pan-London trends. The borough has managed to improve its average ranking if compared to the rest of the MPS and MSG³⁸ (Most Similar Group) average. At the end of the 2013/14, Waltham Forest was ranked 20th (in line with average) from 32 London boroughs.

³⁷ Compared against 32 boroughs in London.

³⁸ Most similar group = other Community Safety Partnerships in England and Wales with similar socio-economic and demographic and crime factors. For Waltham Forest they are Dudley; Sefton; Barnet; Southend on Sea; Enfield; Hastings; Wolverhampton; Croydon; Greenwich; Lewisham; Haringey; Ealing; Brent and Slough. MSG – 15 boroughs.

Performance and review

This section reviews how SafetyNet has worked to tackle the priority problems that were identified in the last strategic assessment. It also describes the key activities that have taken place to address these priorities and an evaluation of their effectiveness where known. These are broken down by their respective programme (Reducing Victimisation, Reducing Offending and Priority Locations) boards that owned each target.

Table 3.4 Reducing Victimisation Programme Board

Reducing victimisation programme board performance report								On target	Off target	2% off target and lower
Indicator			Rolling 12 months			Year to date			Comparison	
		Target	Previous R12	Current R12	% change	Previous YTD	Current YTD	% change	MSG rank	MPS rank
1	Percentage of repeat victims of domestic violence (CAADA)	23.0%	19.0%	21.0%	2%	N/A	N/A	N/A	N/A	N/A
2	Domestic violence – number of cases (Police)	-6.6%	1,822	2,272	24.7%	N/A	N/A	N/A	N/A	N/A
3	Domestic violence – SD rate (Police)	55.0%	43.1%	44.5%	1.4%	N/A	N/A	N/A	N/A	N/A
4	Number of referrals by children social care (MARAC)	No target	3	9	N/A	3	9	N/A	N/A	N/A
5	ASB – first contact within five days (Council)	95.0%	98.3%	96.4%	-1.9%	98.1%	96.0%	-2.1%	N/A	N/A
6	Total ASB demand (Police)	-5.0%	11,213	10,364	-7.6%	N/A	N/A	N/A	N/A	N/A
7	ASB – repeat callers (Police)	-5.0%	299	266	-11.0%	N/A	N/A	N/A	N/A	N/A

Table 3.5 Reducing Re-offending Programme Board

Reducing Re-offending Programme Board performance report								On target	Off target	2% off target and lower
Indicator			Rolling 12 months			Year to date			Quarters	
		Target	Previous R12	Current R12	% change	Previous YTD	Current YTD	% change	Q3	Q4
1	Serious youth violence (MPS TP scorecard)	-5.0%	N/A	N/A	N/A	N/A	N/A	19.2%	N/A	N/A
2	Gun-related crime (EGYV Dashboard)	-5.0%	3	6	100.0%	3	6	100.0%	N/A	N/A
3	Knife-related crime (EGYV Dashboard)	-5.0%	95	120	26.3%	87	113	29.9%	N/A	N/A
4	Successful completion (DiP)	20.0%	N/A	N/A	N/A	N/A	N/A	N/A	24.0%	N/A
5	Re-offending IOM (Police)	-5.0%	N/A	N/A	N/A	151	136	-9.9%	18	38
6	Re-offending YOT (Council)	-2% (1.08)	N/A	N/A	N/A	N/A	0.92	N/A	N/A	N/A
7	Use of custody (Council)	45	N/A	N/A	N/A	N/A	19	N/A	N/A	N/A
8	First time entrants (Council)	410	N/A	N/A	N/A	N/A	222	N/A	N/A	N/A

Table 3.6 Priority Locations Programme Board

Priority Locations Programme Board performance report							Off target	2% off target and lower
Indicator			Rolling 12 months			Quarters		
		Target	Previous R12	Current R12	% change	MSG rank	MPS rank	
1	Burglary (Home Office)	-5.0%	2,925	2,741	-6.3%	11	20	
2	Criminal damage (Home Office)	-1.1%	1,879	1,728	-8.0%	4	16	
3	Robbery (Home Office)	-5.0%	1,270	872	-31.3%	11	19	
4	Theft from MV (Home Office)	-7.1%	2,783	2,524	-9.3%	13	27	
5	Theft of MV (Home Office)	0.0%	1,101	884	-19.7%	15	26	
6	Theft from person (Home Office)	-11.3	989	802	-18.9%	14	20	
7	Violence with injury (Home Office)	-6.6%	1,998	2,081	4.2%	12	21	
8	Street drinking (Council)	No target	12	12	0.0%	N/A	N/A	
9	Noise nuisance (Council)	No target	4,911	4,646	-5.4%	N/A	N/A	
10	Fly tipping (Council)	No target	3,309	5,376	62.5%	N/A	N/A	
11	Dangerous dogs (Council)	No target	53	90	69.8%	N/A	N/A	

Priority Locations Programme Board performance report						Off target	2% off target and lower
Indicator			Rolling 12 months			Quarters	
		Target	Previous R12	Current R12	% change	MSG rank	MPS rank
12	Reduction of cost of crime (Borough)	-6.1% (£67m)	N/A	£63.8m	-10.0%	N/A	N/A
13	High Street cost	-6.1% (£4.9m)	N/A	£4.9m	-6.1%	N/A	N/A
14	Lea Bridge cost	-6.1% (£3.4m)	N/A	£4.5m	Up 23%	N/A	N/A
15	Leyton cost	-6.1% (£3.8m)	N/A	£4.2m	Up 4%	N/A	N/A

Crime as an influence on health

The level of crime and fear of crime is one of the most commonly cited influences on people's quality of life. The same social and environmental factors that predict geographic variation in crime rates may also be relevant to explaining community variations in health and wellbeing. Crime is associated with social disorganisation, low social capital, relative deprivation and health inequalities.

Some of the most obvious links to health are the effects of personal violence and assault, which can have both mental and physical health consequences in the short and long term. In addition, crime rates affect people's sense of security and increases their experience of stress. Stress, in turn, causes hormonal levels to rise with potentially damaging health consequences.

Violence may entail physical injury, permanent disability and even death as well as often resulting in time off work and financial losses which can materially affect health.³⁹ In general, victims of violent crime experience deterioration in both their actual and perceived health; they have more chronic limitations on their physical functioning and increased medical consultation.⁴⁰

There is growing recognition that crime is an indicator of collective wellbeing and that areas with high crime rates also tend to exhibit higher mortality rates suggesting that crime and population health share the same origins⁴¹. Poverty and social inequality are two key factors in triggering violence, while social integration presents particular challenges for immigrants. Combined with feelings of being powerless to change their situation, these factors can all contribute to poor health outcomes by turning on a stress response elevating hormones that over the long term can lead to increased infections, diabetes, high blood pressure, heart attack, stroke, depression and aggression.⁴²

As well as the immediate and direct impact of physical violence a range of long-term health risks are associated with victimisation. Increased rates of cigarette smoking, alcohol and other substance abuse, health care neglect, risky sexual behaviour and sleeping and eating disorders are associated with physical and sexual assault.⁴³

³⁹ Shapland *et al.* 1985:97.

⁴⁰ Resnick *et al.* 1993: Shepherd and Farrington, 1993: Ullman and Siegal, 1996.

⁴¹ Kawachi *et al.* 1999.

⁴² Wilkinson, R and Marmot M. 2003. Social Determinants of Health the Solid Facts. Second edition. WHO.

⁴³ Kilpatrick *et al.* 1997.

Strategic priorities

A key aspect of Community Safety process is to refresh the SafetyNet's strategic priorities. The partnership has applied a matrix methodology for determining which areas SafetyNet will focus upon during 2014/15. The priority matrix uses the following variables for each theme to determine whether it should become a priority for the community safety partnership:

- The volume of incidents that have occurred in Waltham Forest
- Whether there has been an increase or reduction in the level of incidents (direction of travel)
- How the partnership is performing against its peers
- The socio-economic cost of each incident (including criminal justice and health costs where available)
- The Safer Neighbourhood Panel priorities for each ward.

Table 3.7 Matrix to determine which areas SafetyNet will focus upon during 2014/15

Priority matrix		Rating criteria					
Themes		Partnership					Theme totals
		Volume	Direction of travel	Comparison against peers	Cost of crime	SNT priorities	
Domestic burglary		4	2	3	3	5	17
Non-residential burglary		2	5	2	3	1	13
Burglary total		5	4	3	3	5	20
Criminal damage		4	2	2	2	4	14
Drugs		3	5	1	5	3	17
Commercial robbery		1	1	5	4	1	12
Personal robbery		3	1	4	4	4	16
Robbery total		3	1	4	4	4	16
ASB		5	2	5	1	5	18
Street population	Begging	1	2	2	1	1	7
	Prostitution	1	2	4	1	3	11
	Rough sleepers	1	2	1	3	3	10
	Dangerous dogs	1	2	5	1	4	13
	Street drinking	1	2	5	1	5	14
Enviro-crime	Abandoned vehicles	1	2	5	1	1	10
	Noise nuisance	5	2	4	3	1	15
	Fly tipping	2	5	1	2	1	11
	Graffiti	2	2	1	2	1	8

Priority matrix		Rating criteria					
Themes		Partnership					Theme totals
		Volume	Direction of travel	Comparison against peers	Cost of crime	SNT priorities	
ASB, street population and enviro-crime total		5	2	4	3	5	19
Theft	Theft from shops	2	5	1	2	3	13
	Theft of pedal cycle	2	2	1	2	1	8
	Other theft	4	5	3	2	3	17
	Theft person	2	4	1	2	1	10
	Theft from motor vehicle	4	3	5	3	4	19
	Theft of motor vehicle	3	1	5	3	3	15
Theft total		5	3	3	4	5	20
Violence	Sexual offences	2	5	1	5	1	14
	Gun crime	1	1	1	5	1	9
	Violence with injury	4	4	2	4	1	15
	Most serious violence	2	5	4	5	1	17
	Alcohol-related violence	3	3	2	4	1	13
	Domestic violence	4	4	5	5	1	19
	Race/hate	2	2	3	4	1	12
	Youth violence	4	4	2	5	3	18
Violence total		5	3	3	5	3	19

A matrix was compiled for each of these variables and the themes divided into five groups (20% quintiles). They were then scored with those in the worst group receiving a score 5, those in the second group 4 and so on. The minimum score available was 1 for each variable. This means that each theme can score between a minimum of 5 (the lowest priority) and 25 (the highest priority).

Based on the data available to date the draft priorities identified include:

- Serious Acquisitive Crime:
 - burglary
 - theft of motor vehicle
 - theft from motor vehicle
 - personal robbery.
- Anti-social behaviour (including street population and enviro-crime)

- Gang-related violence
- Domestic violence
- Other theft.

Gang-related crime was identified due to the cumulative effects it has on other priorities (e.g. robbery), as well as the cross cutting impact on a number of lower scoring issues (i.e. drugs and youth violence). Anti-social behaviour in combination with street population and enviro-crime categories has been identified as one of the top priorities in the borough. Performance monitoring of the priorities agreed is managed in the relevant programme board performance reports. Additional priorities could be included depending on multi-agency tasking; (e.g. other qualitative performance measures will be identified and reported on through the Locations Board). Scrutiny of these reports by the programme boards will enable the level of success to be measured.

Although not possible to measure robustly, it is recommended that the partnership includes Prevent as a priority owing to the risks associated with it. This will ensure that issues relating to hate crime are considered by programme boards.

Delivery of SafetyNet priorities

From 2011, SafetyNet restructured its working arrangements to move from a crime type focus to a problem oriented focus, called 'risky people, risky places'.

To this end the partnership structure was rationalised to form three programme boards:

- reducing victimisation
- reducing offending
- priority locations.

These boards are monitored by the Business Management Group (BMG) on behalf of SafetyNet. This approach ensures that resources are concentrated on tackling those most 'risky people', namely those who are at an increased risk of victimisation and those who are at an increased risk of re-offending, and on those 'risky places' in the borough where the highest levels of crime occurs.

It is the responsibility of the three boards to co-ordinate activity to ensure that all of these priorities are appropriately addressed during 2014/15.

London Ambulance Service assault data

To get a wider perspective of victim data, London Ambulance service data on assaults was analysed. Saturday was the peak day with 21:00 – 00:59 hours the peak time.

The profile of those dealt with by the London Ambulance Service comprised of 63% males, with 30 as the peak age. Of note, 39% of assaults were classified as minor assaults.

When the volume of assaults was compared against the population, 15 to 44 age group had a greater than average risk of assault.

This also increased again for males aged over 80 to 84 and females aged 90+. A different pattern emerges when weapons were used as part of the assault, (this includes knives and guns). 88% were males and 16 to 21-year-olds accounted for 42% of all incidents.

Research and evidence from the British Crime Survey and police recorded crime figures show that victimisation is very uneven in nature. In fact, 'victimisation is the best single predictor of victimisation'. Understanding the nature and characteristics of the victims of crime, and in particular those who are most likely to be repeat victims of crime, should enable SafetyNet to develop the most effective strategies to reduce crime in Waltham Forest. For example, London Ambulance Service data shows that most assault victims were males aged 20 to 24 and dealt with on a Saturday evening.

Disability

The British Crime Survey shows that people with disabilities are more likely to be victims of crime than those without disabilities. A recent report by the Equalities and Human Rights Commission, 'Hidden in Plain Sight' reveals that many people with disabilities are becoming victims of offences such as harassment (including verbal and physical abuse), theft, fraud, sexual harassment and bullying.

Evidence found shows that people with disabilities often do not report incidents of harassment, as it may be unclear who to report it to, they may fear the consequences of reporting, or they may fear that the police and other authorities will not believe them. Data from 'Stay Safe' or third-party reporting sites would be useful to help identify the extent of this within Waltham Forest.

People who are unemployed have an increased risk of victimisation for domestic incidents and violence. Students/school children have a significantly increased risk of victimisation for robbery of the person. People who are retired have a significant increased risk of victimisation for opportunistic acquisitive crime. These trends have remained since the previous strategic assessment.

Based on 12 months Multi-Agency Risk Assessment Conference (MARAC) case data, 13% of domestic Violence cases referred involved a victim with a registered disability.

Violence against women and girls

There is growing evidence (and direction from the Government) to move towards tackling the wider violence against women and girls agenda (VAWG). Research on domestic violence has shown that integrated responses result in reduced costs, not just to victim-survivors, but to the statutory and voluntary sectors.

Implementing an effective integrated response to tackle VAWG will result in fewer victims and will have the additional benefit of reducing the cost of repeat victimisation for service providers. In 2012/13, SafetyNet commissioned three different VAWG services in the borough – Independent Domestic Violence Advisor (IDVA) provision through Victim Support, counselling, and support groups for both domestic and sexual survivors of violence through Ashiana Network (two separate contracts) and legal/advocacy support through Report IT.

Repeat victimisation

Victimisation tends to recur, so prior victimisation is usable as a predictor of later crime. British Crime Survey figures have consistently shown that levels of repeat victimisation vary by offence type. It has consistently shown that domestic violence victims are more likely to experience repeat victimisation than victims of other types of crime. The vast majority were victims of domestic violence and as such they would be picked up via the MARAC process.

Hate crimes

There is a growing body of evidence that confirms hate crime and hate-related incidents can have a disproportionate physical and psychological impact on both victims and the wider community as compared to equivalent non-hate-related crimes.

Research⁴⁴ found that racist victimisation often disproportionately impacts upon:

- Partner/spouse relationships
- Children
- Carrying out routine activities (e.g. shopping, socialising etc.)
- Victim's use of public space
- Feelings of insecurity
- Health and wellbeing.

The latter point is particularly significant and is not exclusive to racist victimisation. Research into homophobic motivated crimes found that victims of hate crime often displayed symptoms of post-traumatic stress disorder that have been proven to last up to five years.⁴⁵ In contrast, for comparable crimes without the 'hate' element, the same research found that victims usually experience a decrease in crime-related psychological problems within two years. The hate element makes a great deal of difference; in fact, it makes this crime type unique. Findings from the Pilkington Public Inquiry provided further evidence of the adverse impact that hate crime and targeted victimisation can have on victims and their family members' health and wellbeing.

Waltham Forest Context

Many of the support services provided to victims and witnesses of hate crime and hate-related incidents in Waltham Forest are delivered by charities and local voluntary sector organisations. Listed below are some of the impacts they have identified whilst supporting clients:

- **Physical health:** injuries sustained in an attack – ranging from minor to short-term hospital treatment. Chronic health-related symptoms relating to stress, sleep disturbance, eating disorders, increased substance or alcohol use
- **Mental health:** all victims of serious crime are at risk of psychological trauma, but the problems associated with hate crimes can last longer than for 'random crimes'. In some cases, individuals may continue to experience high levels of stress and fear of crime
- **Social isolation:** avoiding certain areas or activities, withdrawing from groups matching the perpetrators' profile. Staying indoors for safety. Moving to live in a different area in order to feel safe. Not participating in community due to fear of repeat incidents
- **Disrupted education:** This can be because of the emotional and physical impact, missing school – fear of going to school if the perpetrator also attends the same school. Lack of concentration and withdrawing from classroom exercises
- **Financial loss:** many victims suffer financially, for example loss of earnings through sickness, additional cost for home security, relocating property, not using public transport (using taxis or mini cabs)
- **Loss of confidence:** in the public authorities to deal effectively with incidents, loss of self-esteem, the law is not on their side.

⁴⁴ Chahal and Julianne, 1999.

⁴⁵ Herek, Cogan and Gillis, 2002.

What more do we need to do?

With reducing resources available to tackle crime and anti-social behaviour (ASB) in Waltham Forest and with the increased pressure of escalating crime levels due to the continuing economic recession, it is imperative that resources remain targeted upon those most risky people and most risky places in Waltham Forest to maximise the opportunity and impact of reducing crime and ASB in the borough. As crime can be shown to have a key impact upon health it is imperative that health services play a key role in the work of our Community Safety Partnership SafetyNet. This includes input into the programme boards that deliver the work of SafetyNet.

3.5 Air quality

Poor air quality is not just an issue experienced by residents of Waltham Forest, but by everyone who lives in London. Poor air quality can cause serious health problems and reduce life expectancy by up to eight months (Department of Environment, Food and Rural Affairs (Defra), 2010). The most vulnerable people include children and older residents. Individuals particularly at risk also include those with existing respiratory problems and chronic illnesses such as asthma and chronic obstructive pulmonary disease (COPD). There are approximately 690,000 asthma sufferers in London and 230,000 individuals suffering from COPD.

As road vehicles are the biggest contributors to poor air quality in Waltham Forest, residents living near major roads are exposed to particularly high levels of pollution. The Health Effects Institute panel concluded that the evidence is sufficient to support a causal relationship between exposure to traffic-related air pollution and exacerbation of asthma. It also found suggestive evidence of a relationship with onset of childhood asthma, non-asthma respiratory symptoms, impaired lung function, total and cardiovascular mortality, and cardiovascular morbidity, although the data are not sufficient to fully support causality⁴⁶.

There is also a growing body of evidence, presented by the British Medical Association, 2012, showing that prenatal exposure to air pollution is associated with a number of adverse outcomes in pregnancy. These include low birth weight, intrauterine growth retardation, and an increased risk of chronic diseases in later life. Emerging evidence also suggests that long-term exposure to particulate matter, at levels such as those seen in major cities, can alter emotional responses and impair cognition.

The Government estimates that in the UK, the economic cost of health impacts resulting from poor air quality is around £15 billion, while the cost to London is around £2 billion annually (Greater London Authority, 2010), more than the annual health costs of obesity (Defra, 2010). A reduction in pollutant emissions and pollutant exposure will therefore provide significant savings to health services and provide preventive instead of reactive care.

The European Union and the UK Government have set out air quality standards for a variety of pollutants which include limit values that are legally binding. The main aim of these limits is to reduce air pollution in order to improve the health of our residents. In the Mayor of London's Air Quality Strategy document, his vision for air quality is:

'To protect the health of Londoners and enhance their quality of life by significantly improving the quality of the air we breathe in London. This will:

- *Make London a more pleasant place to live and work in*
- *Reduce the burden on health services in the capital*
- *Enhance London's reputation as a green city – making it more attractive to tourists and businesses*
- *Make London cleaner whilst safeguarding its biodiversity'*

⁴⁶ <http://www.comeap.org.uk/images/stories/Documents/Statements/asthma/does%20outdoor%20air%20pollution%20cause%20asthma%20-%20comeap%20statement.pdf>

Air pollution in London

The UK Air Quality Standards Regulations 2000, updated in 2010, sets standards for a variety of pollutants that are considered harmful to human health and the environment. These are based on EU limit values and are for a range of air pollutants, listed below:

- Sulphur dioxide
- Nitrogen dioxide
- Oxides of nitrogen
- Particulate matter (PM10 and PM2.5)
- Lead
- Benzene
- Carbon monoxide
- Benzo(a)pyrene
- Ozone.

The majority of these pollutants are now at concentrations within London that do not affect human health. London is still however experiencing exceedances of particulate matter and nitrogen dioxide.

Particulate matter PM10 and PM2.5

Particulate matter (PM10 and PM2.5) is a complex mixture of non-gaseous particles of varied physical and chemical composition. It is categorised by the size of the particle (for example PM10 are particles with a diameter of less than 10 microns (um)). Most PM emissions in London are caused by road traffic, in Central London this is as much as 80%, with exhaust emission and wear, tyre and brake wear and dust from road surfaces being the main sources. Construction sites, with high volumes of dust and emissions from machinery are also major sources of local PM pollution, along with accidental fires and burning of waste. However, a large proportion of PM originates outside of London (between 40 – 55%) and includes particulates from natural sources, such as sea salt, forest fires and Saharan dust, as well as from sources outside London caused by human activity. Similarly London also exports PM to other parts of the UK and Europe. Small particles tend to be long-lived in the atmosphere and can be transported great distances (PM2.5 can reach London from sources such as the Sahara up to 8,000 km away).

PM aggravates respiratory and cardiovascular conditions. The smaller the particle, the deeper it will deposit within the respiratory tract. The health impacts of PM2.5 are especially significant. The Mayor commissioned a study in 2010, which suggested that around 4,300 deaths per year in London are partly caused by long-term exposure to PM2.5 (which is widely acknowledged as being the pollutant which has the greatest effect on human health). Above and beyond this figure the Committee on the Medical Effects of Air Pollutants speculate that air pollution acts as a contributory factor in early deaths from cardiovascular disease. Its impacts are most severely felt by vulnerable people such as children, older people and those with existing heart and lung conditions.

Nitrogen dioxide: NO₂

All combustion processes produce oxides of nitrogen (NOx). In London, road transport and heating systems are the main sources of these emissions. NOx is primarily made up of two pollutants – nitric oxide (NO) and nitrogen dioxide (NO₂). NO₂ is of most concern due to its impact on health. However NOx easily converts to NO₂ in the air – so to reduce concentrations of NO₂ it is essential to control emissions of NOx.

At high concentrations NO₂ causes inflammation of the airways and long-term exposure can affect lung function and respiratory symptoms. It can also increase asthma symptoms. The health impacts of NO₂ are less well understood than those of PM10 as less research has been undertaken in this area.

Air pollution in Waltham Forest

Waltham Forest Council has been monitoring the borough's air quality for over 10 years. Monitoring has confirmed that the borough experiences exceedances of the annual and hourly mean objectives for NO₂. As a result of these exceedances, Waltham Forest is an Air Quality Management Area (AQMA) for NO₂ and particulates and is working towards improving air quality for its residents. While significant improvements may not be felt for a while, it is important to educate our residents on the issues relating to poor air quality and their health. Funding is needed to support such educational activities and the Council is continuously applying to Department of Environment, Food and Rural Affairs (Defra) for funding for such educational and air quality improvement projects. The council is also liaising with the Greater London Authority and Transport for London for further support.

The Council also considers air quality to be a material consideration in development control decisions. As such, planning often requires air quality assessments to be conducted prior to planning permission being given and also insists on strict mitigation measures which reduce pollutant emissions from the development and also reduces pollutant exposure for future occupants and neighbouring residents.

The Council also periodically participates in school information projects, educational programmes created for schools in the borough designed to educate school children on air pollution and work to lessen our impact on air quality. The programme highlights sustainable modes of travel to and from school and tries to reduce the number of students travelling to school by car by promoting walking and cycling. The programme also identifies safe routes, promotes exercise and community involvement.

Information on air quality in our borough can be found on the Council's website via the following link:

<http://www.walthamforest.gov.uk/Pages/Services/Pollution-control-air-quality.aspx?l1=100003&l2=200075#Airqualitypolicyreportsandresearch>

Our residents are also encouraged to use sites such as airText which is a free service that alerts residents when air pollution levels are raised so that they can take precautions to help reduce the likelihood of any health impacts on them. Their website is <http://www.airtext.info/>

Another free service our residents are encouraged to use is walkit.com, a web-based urban walking route planner that plans walking or cycling routes around London while avoiding the most polluted routes. This is a great tool for urban joggers, as jogging in heavily polluted roads increases the uptake of pollutants into the lungs such as particulates which have been linked to causing cancer.

As established by the Environment Act 1995 Part IV, all local authorities in the UK are under a statutory duty to undertake an air quality assessment within their area and determine whether they are likely to meet the air quality objectives set down by government for a number of pollutants. Waltham Forest Council as part of this statutory duty has undertaken air quality assessments within their borough, resulting in the declaration of a borough-wide AQMA for nitrogen dioxide (NO₂) and particulates (PM10), including both long-term and short-term Air Quality Strategy objectives for these pollutants. Figure 3.4 and 3.5 show 'hotspot' locations in Waltham Forest, mostly along major roads.

Figure 3.4 PM10 ‘hotspot’ locations in Waltham Forest

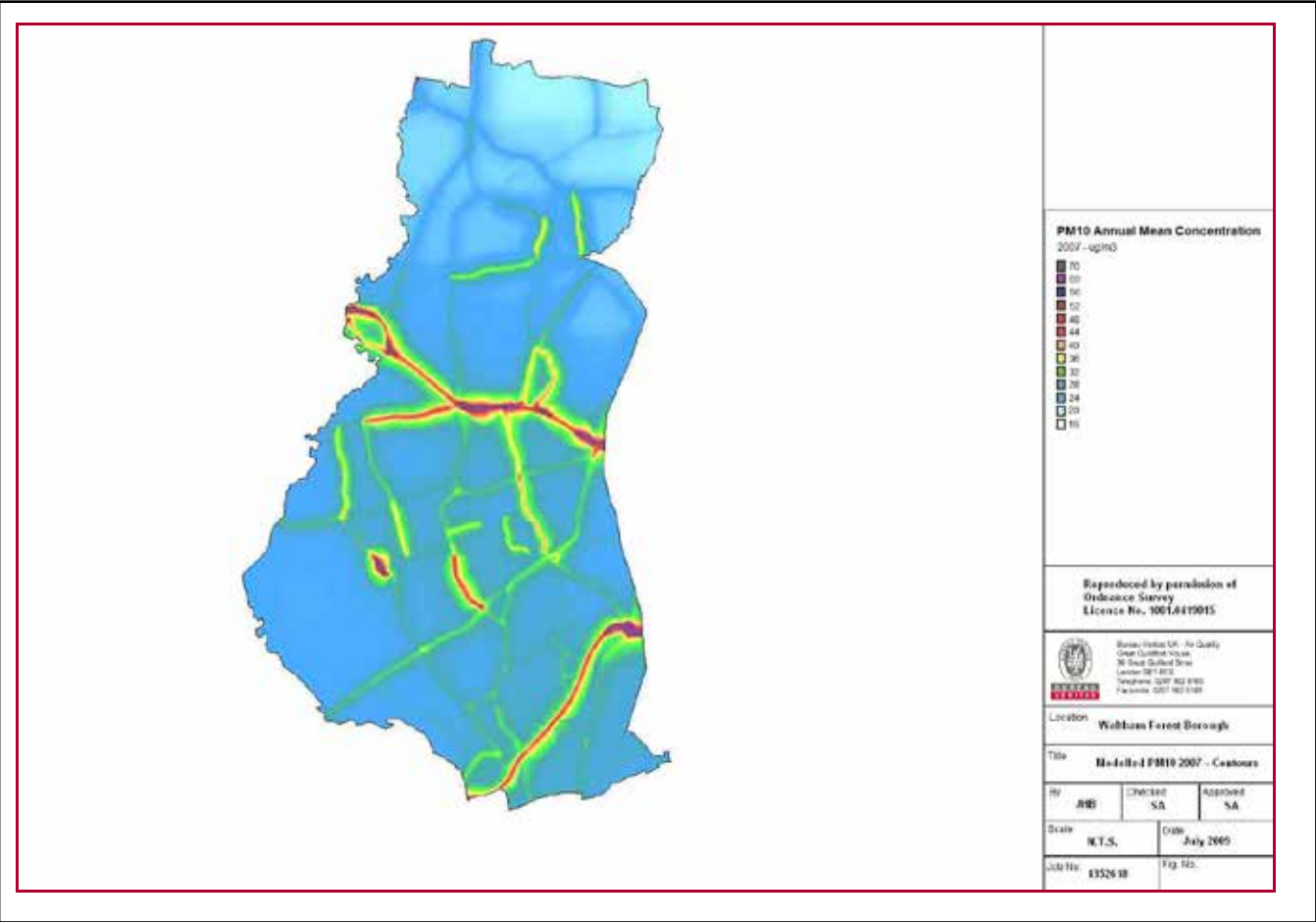
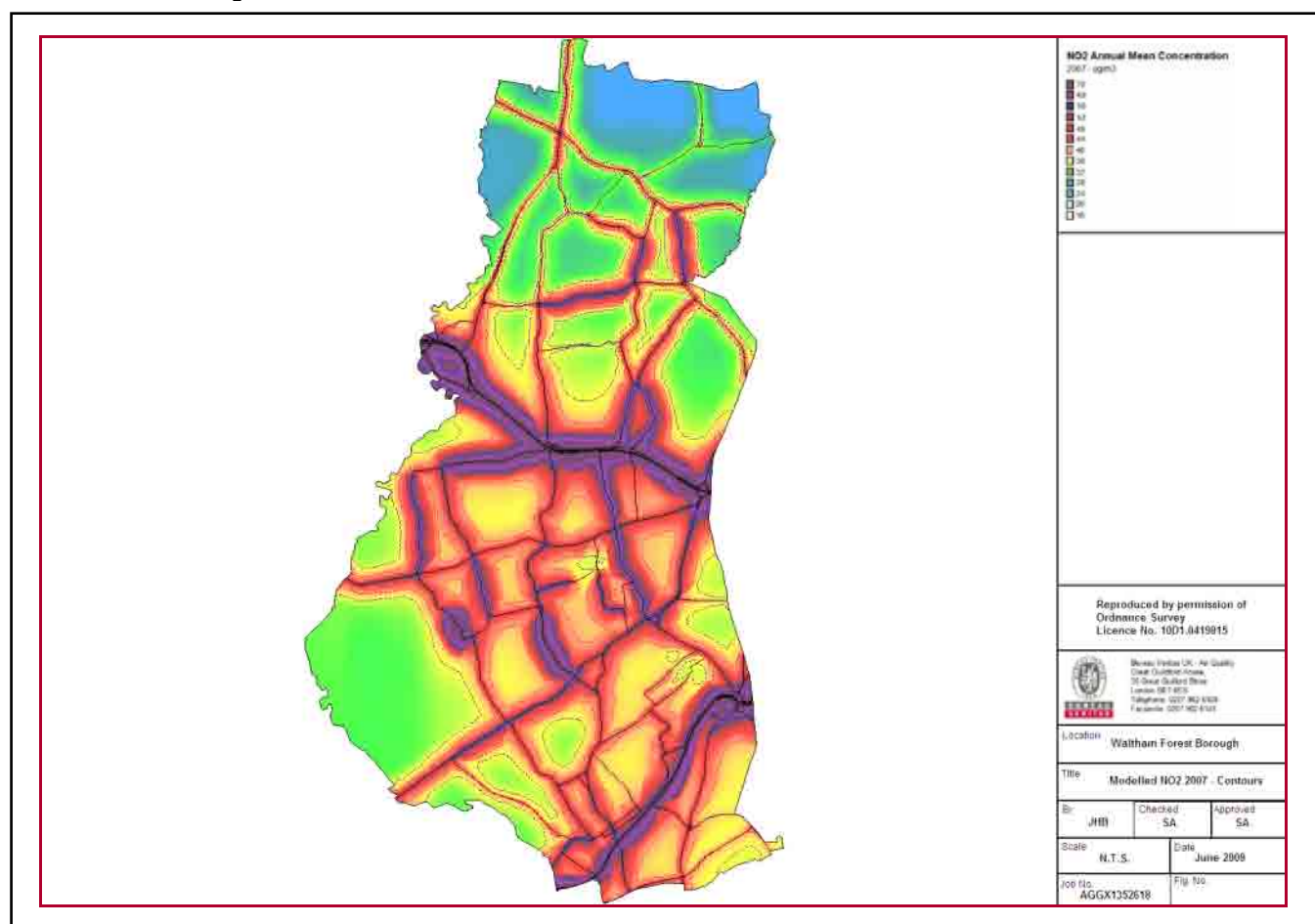


Figure 3.5 NO₂ 'hotspot' locations in Waltham Forest

Health impacts in the London borough of Waltham Forest

The Public Health Outcomes Framework includes a benchmark tool, which enables the comparison of the fraction (%) of mortality attributable to long-term exposure to particulates (PM_{2.5}) in each local authority in the UK. This can be compared to the UK average which is 5.6% of mortality attributable to long-term exposure to PM_{2.5}.

The statistics for each of the London boroughs are included in Table 3.8 below. Waltham Forest is 1.7% higher than the UK average and is ranked 21st in London.

Table 3.8 Fraction (%) of mortality attributable to long-term exposure to PM2.5

Local authority	Fraction (%) of mortality attributed to long-term exposure to PM2.5
Bromley	6.3
Havering	6.3
Harrow	6.4
Sutton	6.4
Croydon	6.5
Hillingdon	6.5
Bexley	6.6
Enfield	6.6
Kingston Upon Thames	6.7
Barnet	6.8
Richmond upon Thames	6.8
Merton	6.9
Redbridge	7.0
Dagenham	7.1
Haringey	7.1
Hounslow	7.1
Brent	7.2
Ealing	7.2
Greenwich	7.2
Lewisham	7.2
Waltham Forest	7.3
Wandsworth	7.3
Newham	7.6
Camden	7.7
Lambeth	7.7
Hackney	7.8
Hammersmith and Fulham	7.9
Islington	7.9
Southwark	7.9
Tower Hamlets	8.1
Kensington and Chelsea	8.3
Westminster	8.3
City of London	9.0

This research is comparable to research which was carried out by the Institute of Medicine (IOM)⁴⁷ which also estimates the mortality impacts of PM2.5 in London. The overall findings from this research show that 4,267 deaths in London could be attributed to long-term exposure to PM2.5 in 2008. This is the statistic which is included in the Mayor's Air Quality Strategy. 'Attributable deaths' do not represent a subset of all deaths that are solely caused by PM2.5, everyone living in London breathes the air and their health is impacted, when the risk to all the individuals is combined it is equivalent to this 'attributable' number of deaths. The IOM research determined that in 2008, 129 deaths were attributable to PM2.5 in Waltham Forest. Table 3.9 below, provides an estimated breakdown of the number of deaths attributable in each of the wards in the borough based on population size.

Table 3.9 Estimated number of deaths attributed to exposure to PM2.5 pollution in 2008 in wards in the London Borough of Waltham Forest

Ward	Total population	Annual deaths attributed to exposure to PM2.5
Cann Hall	11,792	7
Cathall	10,981	6
Chapel End	11,965	7
Chingford Green	9,742	5
Endlebury	10,284	6
Forest	10,971	6
Grove Green	11,832	7
Hale End and Highams Park	10,199	6
Hatch Lane	10,072	6
High Street	11,959	7
Higham Hill	11,441	6
Hoe Street	12,041	7
Larkswood	10,869	6
Lea Bridge	12,927	7
Leyton	13,705	8
Leytonstone	11,718	7
Markhouse	10,745	6
Valley	10,064	6
William Morris	11,527	6
Wood Street	11,872	7
Total	226,706	129

⁴⁷ www.iom.edu/

What can we do to improve air quality?

As road traffic is the most significant contributor to poor air quality in Waltham Forest, consider alternative modes of transportation such as walking, cycling, public transportation or car-pooling. If a person is required to use their vehicle, ensure that it is properly maintained and that no dark smoke is being emitted from the exhaust. Consider leaving your car at home one day of the week and using public transportation instead. Don't leave your car idling when stopped. At home, avoid burning waste or using your fireplace. If you do use your fireplace, ensure it is an exempt appliance or that you are using an approved fuel. You can get further information on this by visiting <http://smokecontrol.defra.gov.uk/background.php>

Ensure your boiler is running as efficiently as possible and consider installing an ultra-low NOx boiler if you are installing a new boiler. Also, consider having an electric stove instead of gas.

What can I do to reduce my pollutant intake?

If you enjoy sports, ensure that you are not exercising near a busy road. Try to exercise during times when traffic is reduced. Take advantage of the free AirText and walkit.com services, these are especially good services for those who suffer from respiratory and cardiovascular illness. Speak to your GP or get in touch with your local authority air quality officer for further information.

3.6 Education

Executive summary

Education, along with poverty, is the most important influence on health. The education indicator that is used to define the influence on health is the level of completed education in the population. Waltham Forest had a lower percentage of working-age residents with qualifications to NVQ Level 4 or above (degree and higher degree level qualification) (41.4%) than London (47.6%) though not England (34.2%). The level of working-age population who held no recognised qualifications in 2012 was 11.1%, compared to 8.4% for London and 9.5% for England.⁴⁸

At Key Stage 2 (pupils age 7 to 11) Waltham Forest had results that compare well to the England average. At Key Stage 4 improvements have been made in the percentage of pupils gaining five or more A*-C plus English and maths GCSEs over the last five years though the borough is still at the lower end of the scale across London. At A Level (Key Stage 5) results for Waltham Forest pupils are lower than they are for England as a whole.

Waltham Forest was well above the London average for the number of Entry Level 1 qualifications in literacy achieved in 2008/09 though much closer to the London average for numeracy.

The percentage of pupils at both primary and secondary school that had special educational needs (SEN) in 2013 was high at 20.2% and 24.0% compared to the London average of 16.5% and 18.9% respectively⁴⁹.

Education as an influence on health

Education offers opportunities for significant improvements in life expectancy and inequalities. While increases in education will take years to have an impact, the impact will affect people's lives for years. Education is linked to the ability to earn higher incomes, which in turn enables people to adopt healthier lifestyles such as never or quitting smoking. The Institute of Education published a report giving examples:

- 'for every 100,000 women enrolled in adult learning in the UK an estimated 116–134 cancers could be prevented because of greater take-up of cervical smear tests'
- 'one more year of education has been shown to increase life expectancy in the US by as much as 1.7 years'
- 'success or failure at school is strongly related to propensity to commit crime or engage in anti-social behaviour' and 'a 16 percentage point rise in those educated to degree level could save this country more than £1 billion annually in reduced crime costs'
- '...when poor achievement is coupled with poor engagement (measured by truancy from school) the risk of ill health in adulthood multiplies by 4.5.'⁵⁰

⁴⁸ Working Age Client Group, DWP through Nomis.

⁴⁹ Department of Education – 2013 percentage of pupils with SEN, maintained primary and secondary schools without statements.

⁵⁰ Feinstein L, Budge D, *et al.*, The social and personal benefits of learning: a summary of key research findings October 2008. IOE.

Over the 20th century, reductions in chronic disease and mortality did result from increasing numbers of UK citizens improving their education, jobs and income. Investment in education has much wider benefits than just increasing a country's economic competitiveness. It saves thousands of premature deaths. These findings from the Institute of Education and others suggest that increasing levels of education in Waltham Forest offers the potential to target disadvantaged groups to reduce the health gap.

Adult qualification/skills levels

41% of the working-age population (16 to 64 years old) in Waltham Forest are qualified to NVQ Level 4 or above (degree and higher degree level qualification). This compares poorly with London (48%) though is higher than the England average of 34%. In 2012, 11% of the working-age population (approximately 17,000 residents) held no recognised qualifications. This number was 8.4% for London and 9.5% for England.⁵¹

Key Stage 2 results

Waltham Forest's Key Stage 2 (pupils aged 7 to 11) results are broadly comparable to the England and London averages.

Pupils who meet level 4 have achieved the level expected of most 11-year-olds whilst those who meet level 5 are achieving beyond the expected level.

The most recent data (2012) shows a smaller percentage of pupils achieving Level 4 or above in English (84%) or mathematics (84%) compared to the London average of 87% and 86% respectively. The English averages are 86% (English) and 84% (mathematics).

The percentage of pupils achieving level 5 in English (25%) and mathematics (31%) is lower in Waltham Forest than across London (30% and 37% respectively) and England (29% and 35% respectively).

The percentage of pupils progressing by 2 levels between Key Stage 1 and Key Stage 2 for English (91%) is marginally higher than the England average (89%) and comparable to the London average (92%). For Mathematics the same pattern persists with Waltham Forest (88%) coming out marginally higher than England (87%) though lower than London (90%).⁵²

GCSE/Key Stage 4 results

Waltham Forest is at the lower end of the scale across London regarding results at GCSE although improvements have been made in the percentage of pupils gaining five or more A*-C GCSE's including English and Mathematics over the last five years.

In 2012, 77% of all pupils at the end of Key Stage 4 (pupils aged 14 to 16) achieved five or more A*-C grades at GCSE or equivalent, which means Waltham Forest still has the second lowest results across the 32 London boroughs⁵³. The average in London is 84%.⁵⁴

This position is maintained when GCSE English and mathematics are included in those five or more A*-C GCSE's. By this measure, the London average in 2012 drops to 62.3% of all pupils and 52.6% in Waltham Forest. When split by gender it is apparent that results for boys in Waltham Forest are some way behind girls at 48.3% versus 60.5% respectively.⁵⁵

However, there has been some progress since 2005, with consistent improvements in the percentage of pupils gaining five or more A*-C GCSE's including English and mathematics.

⁵¹ Annual Population survey through Nomis, ONS and London Skills and Observatory website www.lseo.org

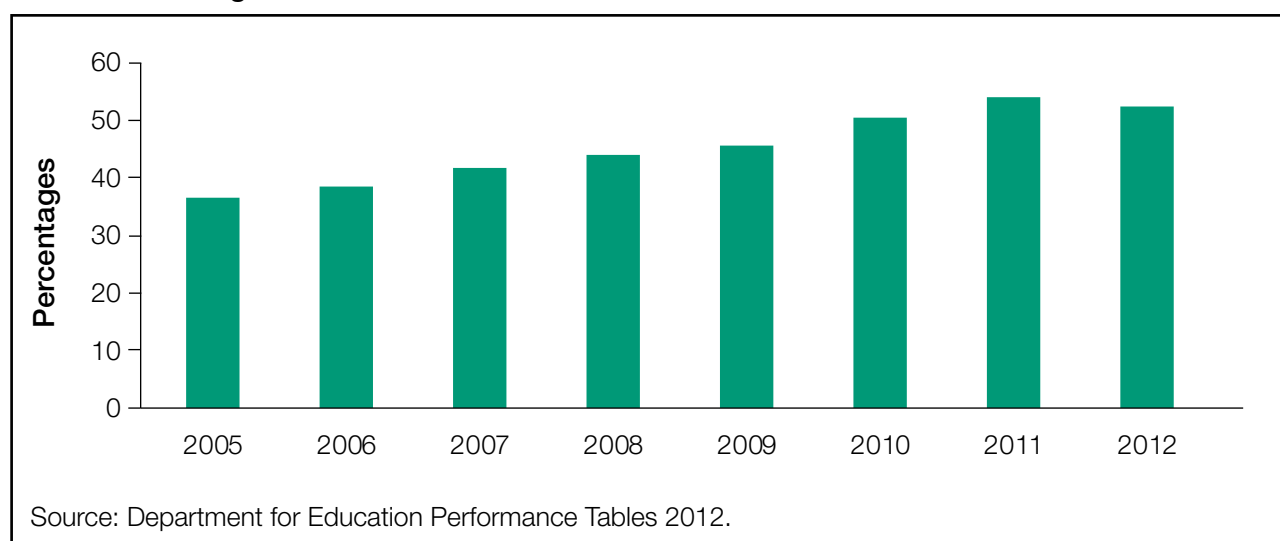
⁵² Department for Education Performance Tables 2012.

⁵³ No results are provided for City of London.

⁵⁴ Department for Education Performance Tables 2012.

⁵⁵ *Ibid.*

Figure 3.6 Percentage of Waltham Forest pupils gaining five or more A*–C GCSE's including English and mathematics



GCE (A Level)/Key Stage 5 results

Results at A Level/Key Stage 5 (pupils aged 16 to 18) are also lower in Waltham Forest than they are in England and London. For 2012, the average point score per pupil in Waltham Forest was 624.1 compared to 733 for England and 695.1 for London. The average point score provides a measure of the average number of A level equivalents studied and the grades achieved. For example, a single grade 'A' at GCE/A Level is worth 270 points, a grade 'C' 210 points and a grade 'E' 150 points.

Since 2006 the average point score per pupils in Waltham Forest has risen from 611 to 691.⁵⁶ However, In 2011 this was 691 and has fallen to 624.1 in 2012.

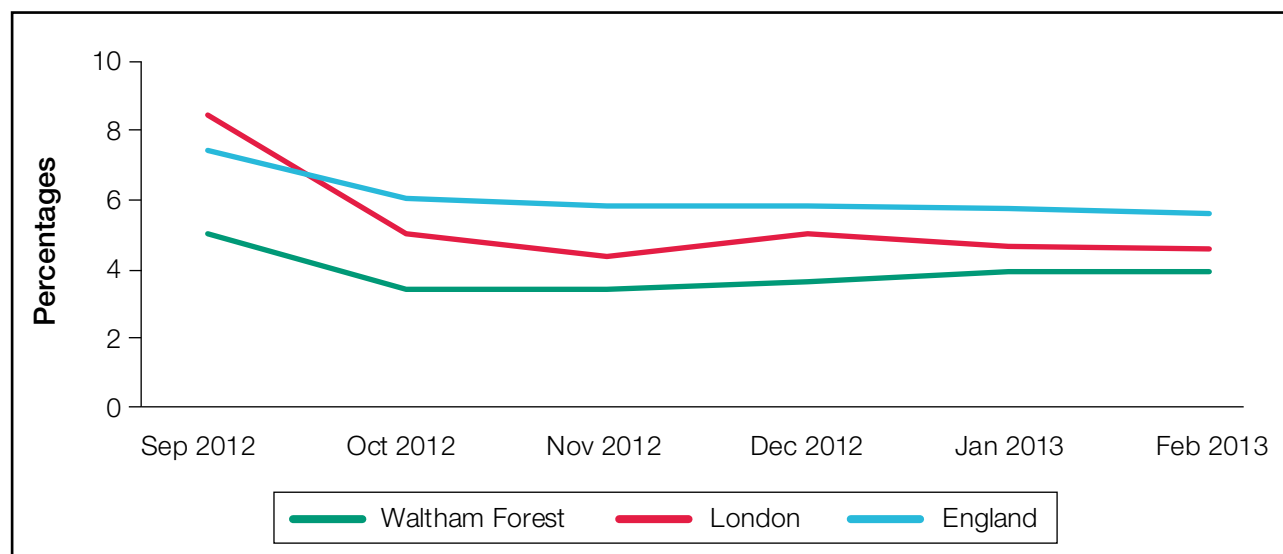
Not in employment, education or training (NEETs)

Data on those not in employment, education or training has recently been revised so that it now relates to academic age 16 to 18 which includes some information on those with an actual age of 19 and the information is now calculated on where a young person is resident and NOT as previously where educated.

Using this new method the number of 16 to 18-year-olds not in employment, education or training in Waltham Forest fluctuates on a monthly basis but in the five months to February 2013 varied between 296 (September 2012) and 338 (February 2013). In 2012 the proportion of 16 to 18-year-olds who were classified as NEET's was 3.7%.

⁵⁶ Department for Education Performance Tables 2012.

Figure 3.7 The proportion of 16 to 18-year-olds, who are not employed, not in education or not in training, September 2012 – February 2013



National indicator data for the years 2005 to 2012 showed that Waltham Forest had consistently lower levels of those not in employment, education or training compared to either London or England. In the five months since September 2012 the proportion of 16 to 18-year-olds who were classified as NEET's across London as a whole varied between 4.4% and 8.3%.⁵⁷

Basic literacy and numeracy levels

Waltham Forest was well above the London average for the number of Entry Level 1 qualifications in literacy achieved in 2008/09, as shown in the table below. Level 1 qualifications for literacy include qualifications such as English for speakers of other languages (ESOL) and other entry-level certificates.

By comparison the number of Entry Level qualifications achieved in Waltham Forest for numeracy was much closer to the London average, 694 versus 590.

Table 3.10 Literacy and numeracy levels

Indicator	Latest data	Waltham Forest value	Waltham Forest rank (out of 33)	London average
NI161: number of Entry level 1 qualifications in literacy (including ESOL) achieved	2008/09	2,510	3	1,480
NI162: number of entry level qualifications in numeracy achieved	2008/09	694	12	590

Source: Skills Funding Agency Individualised Learner Record.

⁵⁷ London Skills and Employment Observatory (data as at February 2012) via DfE and Connexions
<http://lseo.org.uk/data/local-data>

4

**Looking after
your health**

4.1 Tobacco use

Executive summary

Smoking is the leading cause of health inequality in the borough and remains a significant public health issue. Smoking is known to be a contributing factor to 47 diseases, mainly cancers, cardiovascular disease and poor lung health but also some digestive disorders, vision and fertility problems.

The key statistics for Waltham Forest are:

1. The estimated smoking prevalence in residents employed in the Routine and Manual sector is 31.5%, significantly higher than the estimated prevalence in the local population as a whole (19.4%).
2. Analysis of locally available data reveals that male residents have a much higher recorded prevalence (26%) than female residents (17%).
3. The rates of smoking attributable hospital admissions (aged 35 and above) per 100,000 population is among the highest in the country.
4. The cost per resident of those admissions is approximately £40.50 per year.
5. The number of people using free local stop smoking services has declined in recent years.

Recommendations

1. Ensure the Local Stop Smoking Service actively maintains accessibility levels that reflect the full diversity of Waltham Forest.
2. To reduce availability and desirability of tobacco products including shisha to young people through work in schools. £35,000.
3. Invest in alternative services for preventing smoking take up or reducing harm £40,000.

Tobacco and health in England

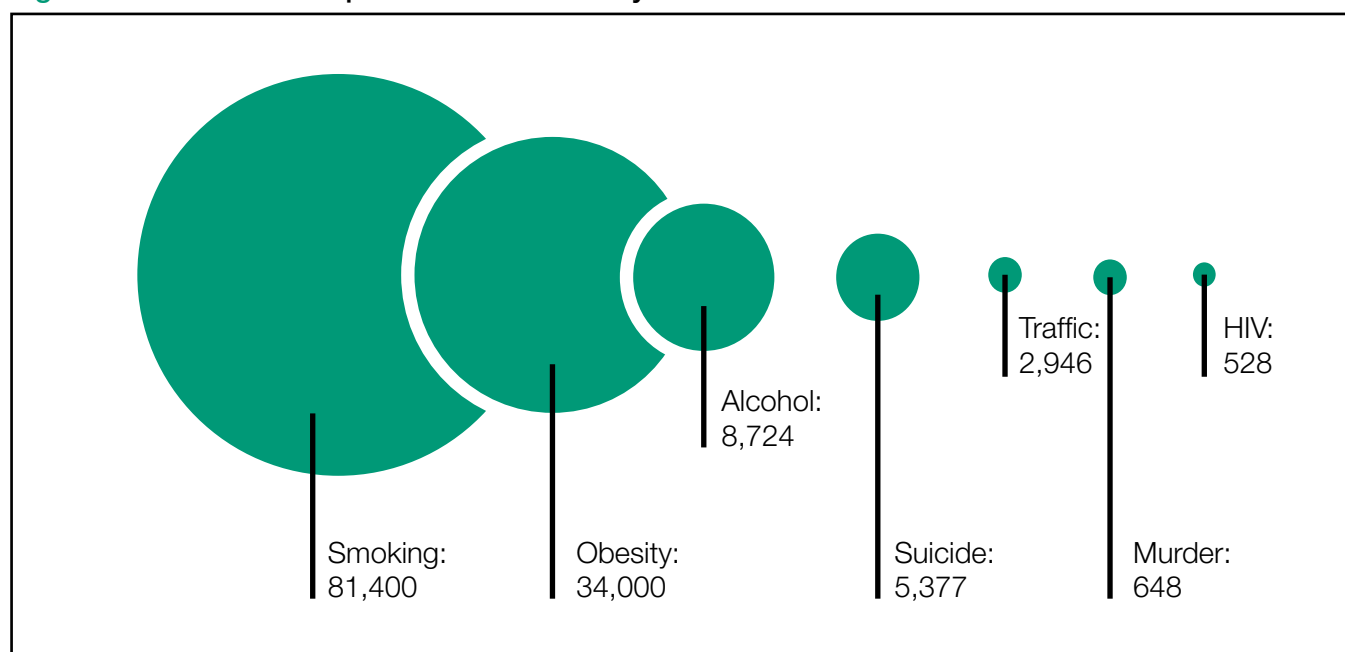
Prevalence

Tobacco use is one of the most significant public health challenges in England. Cigarette smoking is the main type of tobacco use and whilst smoking rates have been in decline over decades, smoking rates have changed little since 2007, with 20.0%⁵⁸ of people in England continuing to smoke.

Mortality

Smoking is the main cause of preventable poor health and premature death, accounting for 81,400 deaths in England in 2009. This is equivalent to 18% of all deaths in adults aged 35 and over. Smoking-related mortality rates are higher among low income groups. In 2009, this was far greater in number than the six most common causes of preventable deaths combined. (81,400 compared to 52,224). See Figure 4.1.

⁵⁸ London Health Observatory Tobacco Control Profiles 2013.

Figure 4.1 Number of preventable deaths by cause

Risk factors

Smoking rates vary considerably between different social groups and it is most common among people who earn the least, and least common among people who earn the most. In recent times, smoking has become one of the most significant causes of health inequalities. The independent review into health inequalities in England undertaken by Professor Sir Michael Marmot culminated in the publication in 2010 of *Fair Society, Healthy Lives*. The review identified the most effective evidence-based strategies for reducing health inequalities in England and made the following recommendation:

Tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups. Smoking-related death rates are two to three times higher in low-income groups than in wealthier social groups.

Impact on the individual

Smoking is a significant cause of preventable poor health and death. Half of regular, lifetime smokers will die before the age of 70 due to tobacco smoke⁵⁹. It is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD, bronchitis and emphysema) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.

Smoking is a difficult habit to stop. Research indicates that there are a number of genetic, environmental and physiological factors linked to nicotine addiction. Research using imaging of the brain indicates that smoking cigarettes can change the physical structure of receptors in the brain⁶⁰. Preventing people from taking up smoking is essential to reducing the health and economic inequalities associated with smoking tobacco. The publication of harm reduction for smokers released by the National Institute for Health and Care Excellence (NICE) offers an evidenced-based approach to helping smokers who cannot quit⁶¹.

⁵⁹ Doll R, *et al.* Mortality in relation to smoking: 50 years' observations on male British doctors. *BMJ* 2004; 328: 1519.

⁶⁰ Harm reduction in nicotine addiction, helping people who cannot quit. A report by the Tobacco Advisory Group of the Royal College of Physicians, October 2007.

⁶¹ PH45 Tobacco Harm Reduction, National Institute of Health and Care Excellence June 2013.

Impact on business

The overall economic burden to society is in excess of £13.74 billion a year.

Impact on the NHS

Treating smoking-related illness cost the NHS £2.7 billion pounds, or £50 million a week.

The local picture

The Tobacco Control Profiles published by Public Health England (2013) calculate that:

- 19.4% of the general population aged 18 and above were estimated to be current smokers in 2011/12
- 31.5% of local residents who work in the Routine and Manual field are estimated to be current smokers
- 1,650 per 100,000 population is the rate of smoking attributable hospital admissions in aged 35 and over. This is among the top five highest admission rates in London and among the highest in the country.

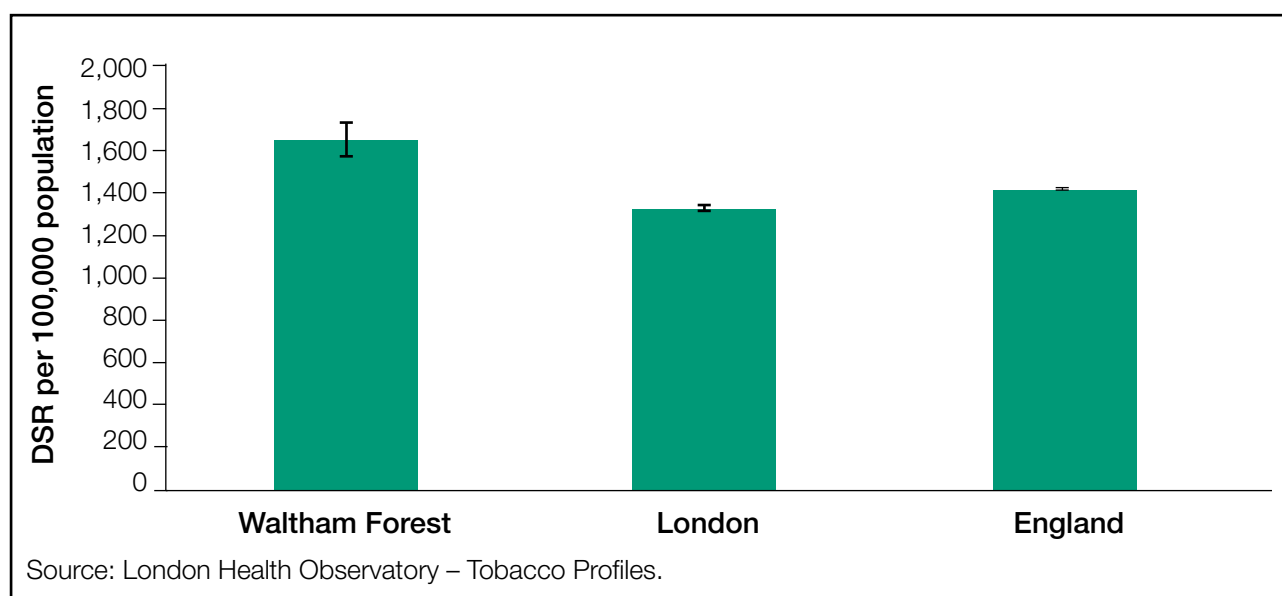
Mortality

Smoking is the leading cause of premature deaths internationally, nationally and in Waltham Forest. The biggest killers are heart disease, stroke, lung cancer and COPD. In 2007–09, deaths from those diseases calculated to be attributable to smoking were higher than the London and England averages, although not statistically different from the national average. Mortality rates attributable to smoking are statistically worse than the London average.

Admissions

Smoking attributable hospital admissions in Waltham Forest are among the highest in the country, significantly higher than the London and England rates for 2010/11 (Figure 4.2). These admissions include all smoking attributable diseases, including heart disease, cancers, respiratory diseases, intestinal and eye disease. Smoking attributable admissions accounted for 7.5% of all hospital admissions in 2010/11, higher than the national average of 5% and the highest in Waltham Forest in a three year period.

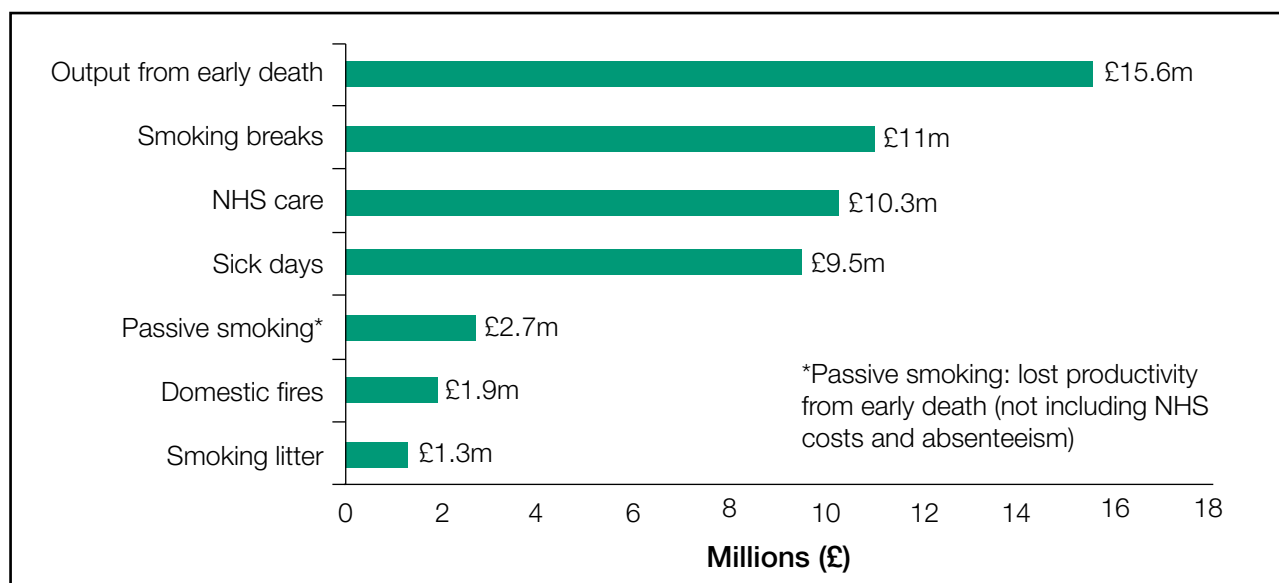
Figure 4.2 Smoking attributable hospital admissions 2010/11



Impact locally

In 2009, the estimated total cost to society of smoking was £52.3 million, or £211 per Waltham Forest resident⁶². NHS care represents the third highest cost to society. The greatest costs are borne by the local economy, which lost over £36m to smoking including the cost of sick days and smoking breaks.

Figure 4.3 Cost of smoking in Waltham Forest in 2009



In contrast Waltham Forest smokers spend an average of £59.2million a year on tobacco products, which results in £45m of tax.

Impact on individuals

Published costs of smoking to local authorities have been calculated using 2009 data and prevalence information which equates to 33,000 smokers. If the proportion of smoking costs were to be applied directly to the current number of smokers, the estimated cost to Waltham Forest residents in 2012 would be £79m, or £287 per person.

Prevention

Preventing the uptake of smoking will greatly reduce the risk of children developing smoking attributable diseases later in life and is a key priority in the Healthy Lives Healthy People Tobacco Control Strategy for England. It is a multi-faceted approach incorporating health promotion techniques, policy and legislation. Health promotion programmes to prevent the uptake of smoking in childhood have not been commissioned for this borough. Multimedia programmes specifically targeted at young people have been evaluated in recent years.

An evaluation of a programme in Leicester showed the programme to be effective in disseminating the dangers of tobacco smoke, and resulted in non-smokers stating that they were even less likely to start the habit⁶³. Young people who have already started smoking can be treated at NHS Stop Smoking Services from the age of 12, and schools should be in a position to refer students into these services.

⁶² Action on Smoking and Health (ASH) Estimating the Financial Burden of tobacco Use through Modelling; Waltham Forest ready reckoner.

⁶³ Smokescreen evaluation NHS Leicester 2012.

Legislation

Legislation has been shown to be an effective tool for reducing smoking prevalence. It is illegal in England to sell cigarettes to children under the age of 18. Trading Standards is the team in the local authority that delivers test purchase activities across the borough to enforce this legislation.

Smoking tobacco using water pipes – also known as shisha – is a practice gaining popularity across London. Shisha smoking in enclosed spaces falls under the same legislation as the smoking ban in bars and shops. Shisha pipes create greater volumes of smoke compared to cigarettes. One half-hour session on a shisha pipe is equivalent to smoking a pack of cigarettes. Cases of carbon monoxide poisoning linked to smoking shisha in enclosed spaces have been recorded by the Health Protection Agency.

In the past few years, England has passed Acts of Parliaments relating to the sale of tobacco products that are designed to protect children from the influence of advertising and tobacco imagery.

6 April 2012 Large shops are required to cover up tobacco product displays and regulate the format and imagery of price lists.

6 April 2015 All shops will be required to cover up tobacco product displays and regulate the format and imagery of price lists.

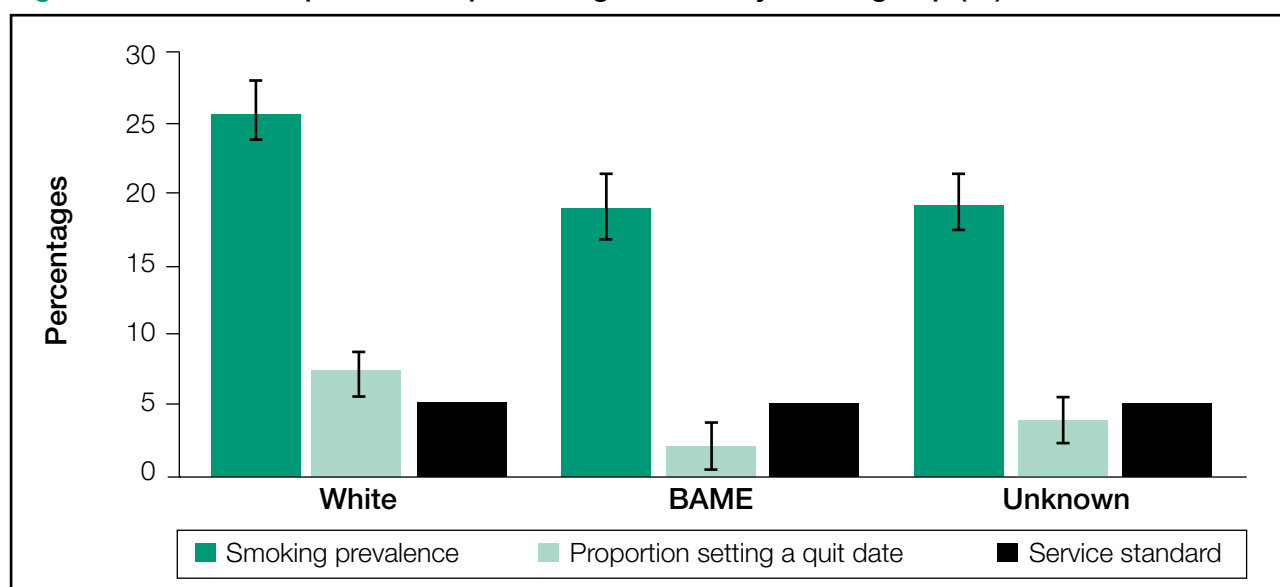
The illegal sale of tobacco products undermines systems put in place to protect individuals from the dangers of cigarette smoke and reduce smoking prevalence in the population. Counterfeit cigarettes often contain higher levels of contaminants than legitimate cigarettes and research shows that four times more people die from the effects of smuggled tobacco than from all illicit drugs combined⁶⁴. The Royal College of Physicians calls for stronger measures to tackle illicit tobacco products as a priority measure for saving lives.

Local services

Specialist stop smoking services

Local Stop Smoking Services have been in operation in the borough for the past 10 years. In recent years use of the service has declined. Assessment of the service indicates that fewer men are using the service and obtaining their stated goal of quitting at 4 weeks. The assessment also indicates that in 2011/12 a lower proportion of smokers from black, asian and minority ethnic groups accessed the service compared to White European smokers. See Figure 4.4.

Figure 4.4 Use of specialist stop smoking services by ethnic group (%)



⁶⁴ Why combating tobacco smuggling is a priority, West R *et al.*, BMJ 2008; 337:a1933.

The service has been commissioned to provide specialist input to people with long-term conditions, users of mental health services, and to increase access to hard to reach and high risk smokers in the population.

Effective interventions

Taxation on cigarettes is known as the most effective means of reducing smoking prevalence in a population. Access to cheaper products such as counterfeit or illegally imported cigarettes undermines this initiative.

The majority of adult smokers report that they became addicted as children and young people. Supporting young people to avoid starting is an effective intervention to reduce prevalence. This is achieved by using three key approaches:

1. Protect young people from the influence of brand marketing through plain packaging and hiding displays.
2. Make it difficult for young people to purchase tobacco products through enforcing existing legislation on sales and tackling the illicit market.
3. Provide school-based educational materials to young people to enable them to resist taking up smoking.

Approximately one-quarter of all adults currently smoke. NHS Stop Smoking Services are proven to help smokers to stop by supporting them through the difficult first month of quitting. The use of these services has declined in recent years in Waltham Forest and a greater focus on advertising and recommending these services to smokers is required across employers, health providers, and local authority services.

What we are doing to address the issues

The NHS Stop Smoking Services and local authority enforcement departments of Trading Standards and Environmental Health have been operational for several years. Evaluation of best practice across the country demonstrates the work of these interventions is more effective when delivered within a robust, multi-sector strategy.

There has been a significant downturn in people accessing services within recent years, and currently there is no youth-based prevention work, essential in protecting children from the harmful effects of tobacco and to reducing prevalence. This is now a commissioning priority for the 2014/15 financial year.

Priorities for next five years

Reducing the prevalence of smoking is the top priority for the borough. This will be achieved through working across health and local authority sectors to provide consistent and robust interventions. The aim of this work will be to:

- To reduce adult (aged 18 or over) smoking prevalence in England to 18.5 per cent or less, concentrating on providing men with greater access to services
- To reduce rates of regular smoking among 15-year-olds in England to 12 per cent or less
- To reduce smoking in pregnancy and exposure to second-hand smoke in the home by working with families.

4.2 Alcohol

Executive summary

Excessive drinking has a huge economic burden on society and it is estimated that the financial burden of alcohol misuse was around £2.7 billion in 2006/07 to the NHS alone. It is estimated that one-fifth of the population in Waltham Forest is drinking above the recommended limits. This is not significantly different from the drinking behaviour in London and Croydon (statistical neighbour). The rate of alcohol related hospital admissions in 2011/12 was higher than London and England.⁶⁵ Alcohol-specific hospital admissions for under 18s in Waltham Forest increased by 21% between 2004/05 to 2006/07 and 2008/09 to 2010/11. This increase is fairly comparable to Croydon and London averages but lower than the England average.

Waltham Forest alcohol-related recorded crimes and alcohol-related violent crimes declined by 16% and 21% respectively between 2006/07 and 2011/12. Alcohol-related sexual crimes went up by 29% between 2006/07 and 2011/12. Most alcohol-related incidents occur in the following wards – High Street, Lea Bridge, Wood Street and Leytonstone. These wards have higher indices of multiple deprivation than the Waltham Forest average. The white British ethnic group continues to be the largest group accessing alcohol treatment. Results from a number of small studies in the UK suggest that there are higher levels of alcohol misuse among lesbian, gay and bisexual people. Commissioners have made significant progress in implementing last year's Alcohol JSNA recommendations (see 'Evidence that we are making a difference section'). Areas requiring improvement over the next five years are categorised into three: Substance misuse commissioning strategy; Prevention and Early Intervention; and Treatment including Recovery.

Recommendations

- Re-commission substance (alcohol and drugs) misuse services in Waltham Forest
- Refresh the current Waltham Forest Alcohol Strategy and implement via the Waltham Forest Alcohol Strategy Group
- Embedding IBA (Identification and Brief Advice) in frontline staff as part of their initial assessment process. This will help to reduce alcohol use to low risk level
- Full analysis of alcohol-related hospital admissions in Waltham Forest is undertaken to establish which particular groups need to be targeted
- Review current alcohol treatment pathway to include prevention, early intervention, treatment and recovery
- Commission IBA from the community pharmacies particularly, those already delivering needle exchange and shared care consumption services. IBA services delivered through community pharmacies are an effective way of raising awareness of alcohol risks with large numbers of people, including those who are not regular users of other health services
- Embedding school-based substance misuse education and interventions into the Waltham Forest school nurses programme

⁶⁵ London Health Programmes – HNA Toolkit.

- Greater utilisation of outreach and safer neighbourhood services to identify street drinking hotspots to refer into appropriate services
- The Local Development Plan includes conservation of pubs as a priority to conserve historic buildings. Work with Planning and Policy to develop a scheme that would work within this to ensure that pubs are social meeting places that control drinking levels and explore licensing/public health initiatives such as All Bar None and Purple Flag
- Undertake a literature review to explore the relationship between alcohol and cannabis combined usage among young people
- Stimulate referral pathways from Primary Care into structured treatment via GP targeted promotion
- Develop a clear pathway to include health promotion outreach service to Designated Public Places Orders (street drinkers enforcement intervention) to ensure that there are effective multi-component interventions to engage with street drinkers to reduce alcohol-related harms in Waltham Forest. Targeting E17 which is known to be a hotspot (Market Square and Coronation Gardens) for problematic street drinkers.

What is alcohol misuse?

The World Health Organisation (WHO) divides alcohol misuse disorders into three categories⁶⁶:

Hazardous drinking (also referred to as increased risk drinking): individuals drinking above recognised 'sensible' levels but not yet experiencing harm. 'Hazardous' limits are defined as the consumption of 22–50 units per week for men, and 15 to 35 units for women.

Harmful drinking (also referred to as higher risk drinking): individuals drinking above recommended levels for sensible drinking and experiencing physical and/or mental harm. The weekly consumption associated with harmful drinking is of more than 50 units per week for men and of more than 35 units for women. Individuals categorised as harmful drinkers have not yet developed alcohol dependence.

Alcohol dependence: individuals drinking above sensible levels, experiencing an increased drive to use alcohol and difficulty controlling its use. Dependent drinking can be sub-divided into two categories; 'moderate' dependence and severe dependence, traditionally known as 'chronic alcoholism'. Dependence can be measured by an Alcohol Use Disorder Identification Test (AUDIT) and a Severity of Alcohol Dependence Questionnaire (SAD-Q).

The term **binge drinking** is used to describe consumption of at least twice the daily recommended amount of alcohol in a single drinking session (eight or more units for men and six or more units for women).

Policy context

The Government's Alcohol Strategy⁶⁷ sets out proposals to crackdown on our binge drinking culture, cut the alcohol fuelled violence and disorder that blights too many of our communities, and cut the number of people drinking to damaging levels.

⁶⁶ Adapted from County Durham and Darlington Alcohol Health Need Assessment 2011: http://www.darlington.gov.uk/dar_public/documents/Community%20Services/Community%20Safety%20Partnership/safercommunities/Alcohol%20Health%20Needs%20Assessment%20Final%20WB.pdf

⁶⁷ The Government's Alcohol strategy: <http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy?view=Binary>

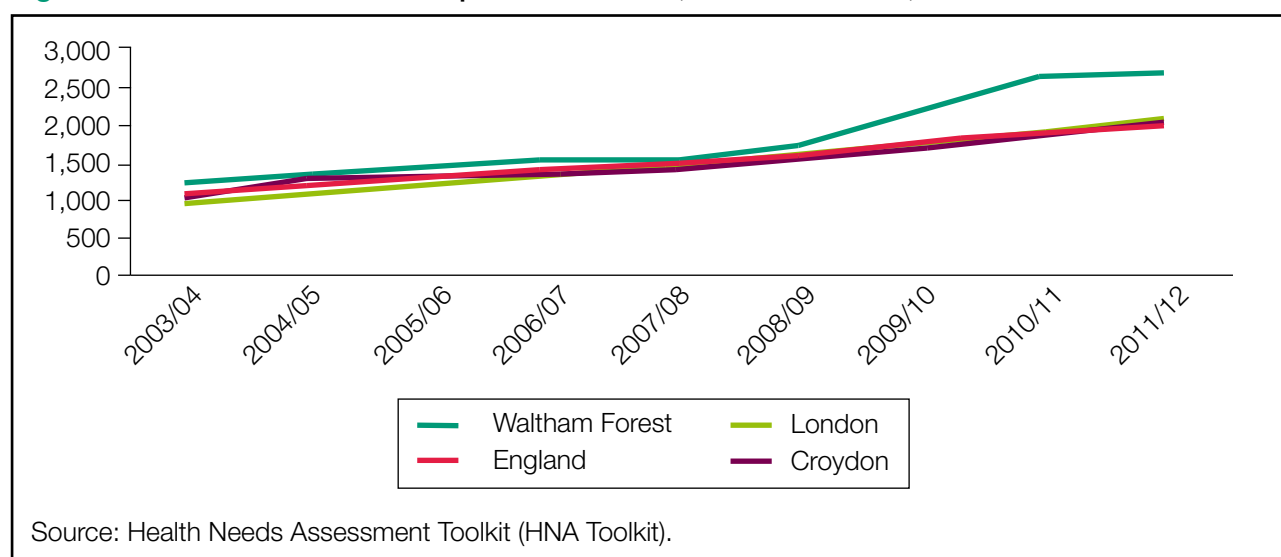
Drinking beyond the recommended daily allowance and particularly binge drinking can put people at an increased risk of developing a number of diseases including cancer, liver disease, mental health problems and stroke. Consequences of excessive drinking have a huge economic burden on society and it is estimated that the financial burden of alcohol misuse was around £2.7 billion in 2006/07 to the NHS alone⁶⁸. This includes accident and emergency attendances, hospital admissions and costs to primary care.⁶⁹ An additional cost involves the societal impact on alcohol related crime and disorder, violence, employment and the economy.

Local picture

It is estimated that one-fifth of the population in Waltham Forest is drinking above the recommended limit. This prevalence is not significantly different from the drinking behaviour in London and Croydon (statistical neighbour)⁷⁰.

Figure 4.5 shows an overall upward trend in alcohol-related admissions in Waltham Forest and its comparators (England, London and Croydon). The rate in Waltham Forest in 2011/12 is higher than the other areas.

Figure 4.5 Alcohol-related hospital admissions, Waltham Forest, 2003/04 – 2011/12



Alcohol attributable recorded crimes⁷¹

Figure 4.7 illustrates that Waltham Forest alcohol attributable recorded crimes and alcohol attributable violent crimes declined by 16% and 21% respectively between 2006/07 and 2011/12. Despite the fact that alcohol attributable recorded crimes and alcohol attributable violent crimes in Waltham Forest have gone down, they were significantly higher than comparators (England, London and Croydon) in 2011/12. Sexual crime attributable to alcohol crimes in Waltham Forest increased by 29% between 2006/07 and 2011/12⁷² and is significantly higher than England average but not significantly different from London and Croydon.

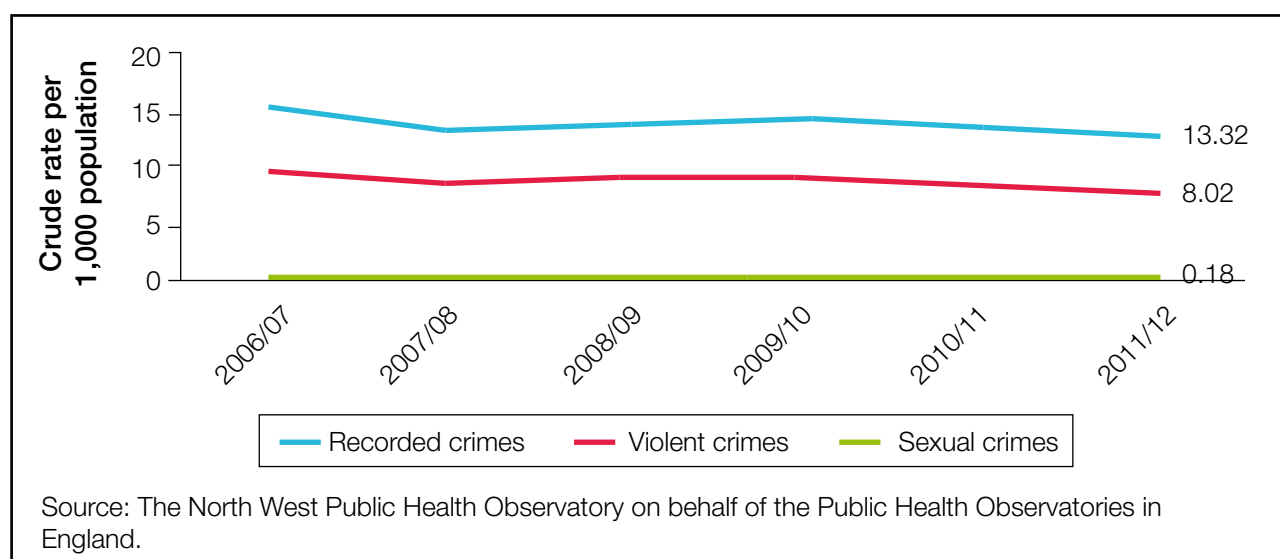
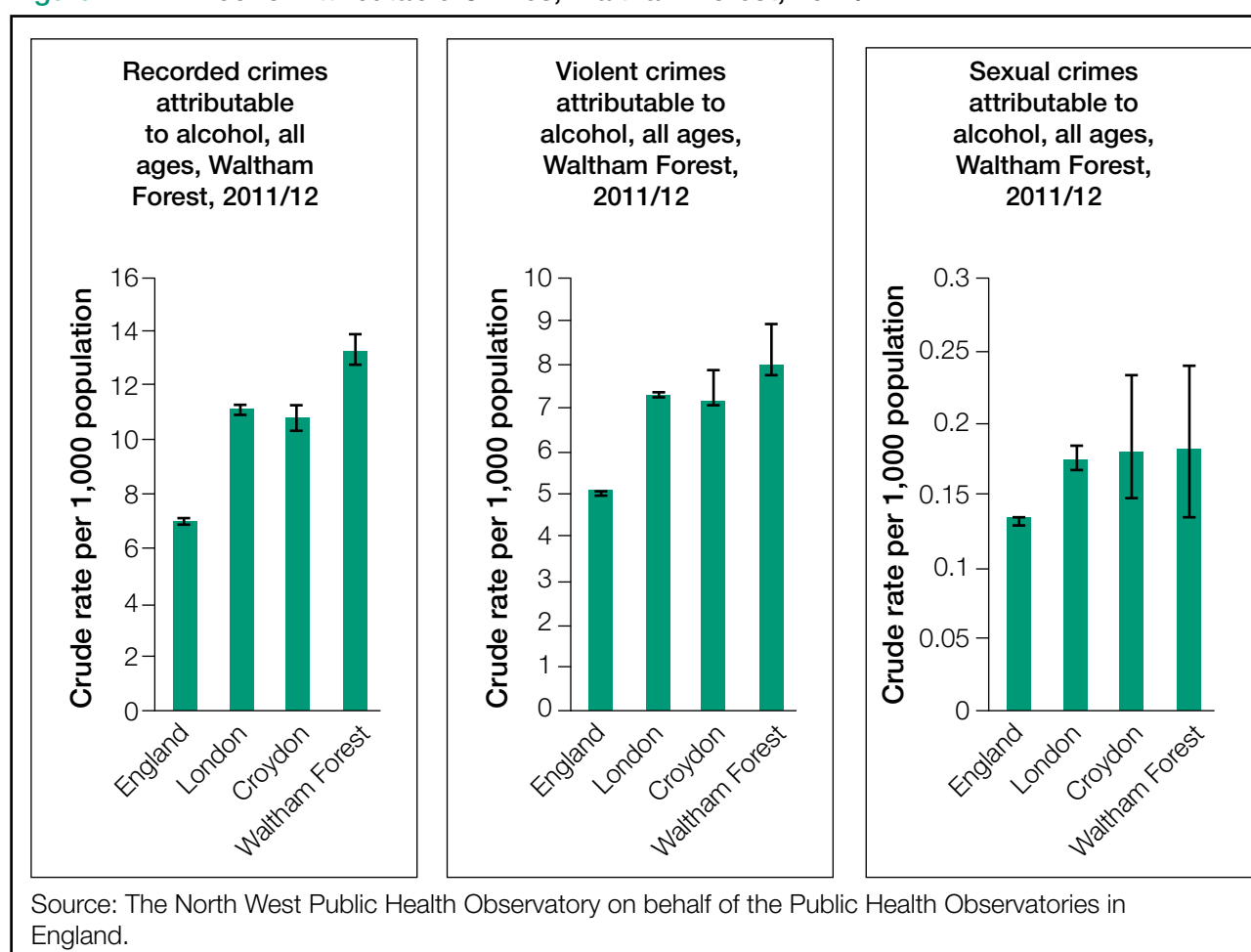
⁶⁸ http://www.nhsconfed.org/Publications/Documents/Briefing_193_Alcohol_costs_the_NHS.pdf

⁶⁹ The cost of alcohol-related harm to the NHS in England, Department of Health. 2008.

⁷⁰ North West Public Health Observatory 2011: Topography of Drinking Behaviour in England: <http://www.cph.org.uk/showPublication.aspx?pubid=747>

⁷¹ Alcohol-related recorded crimes, crude rate per 1,000 population. (NWPHO from Home Office recorded crime statistics 2010/11). Office for National Statistics 2009 mid year population were used. Attributable fractions for alcohol for each crime category were applied, based on survey data on arrestees who tested positive for alcohol by the Strategy Unit: <http://www.lape.org.uk/downloads/LapeLADatasetNWPHO07092011.xls>

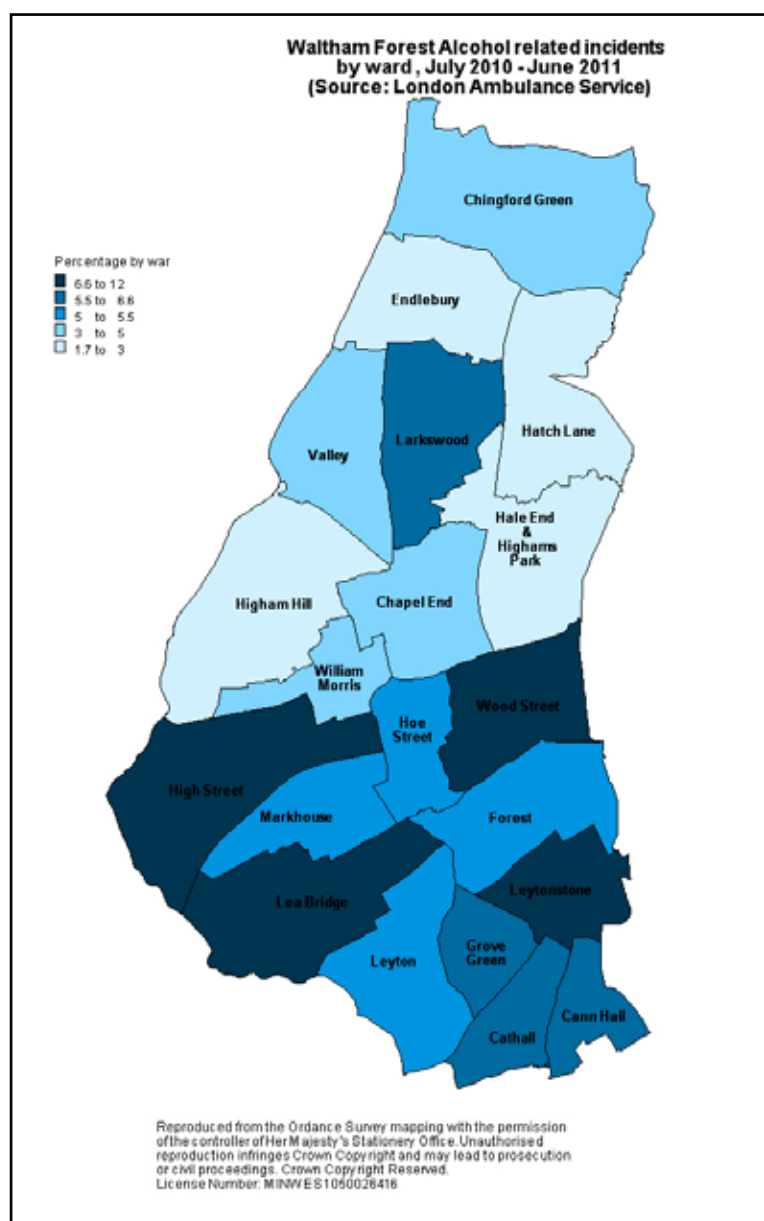
⁷² The North West Public Health Observatory on behalf of the Public Health Observatories in England.

Figure 4.6 Alcohol attributable crimes, Waltham Forest, 2006/07 – 2011/12**Figure 4.7** Alcohol Attributable Crimes, Waltham Forest, 2011/12

Alcohol-related incidents by ward

Figure 4.8 illustrates that most alcohol-related incidents occur in the following wards – High Street, Lea Bridge, Wood Street and Leytonstone. These wards have higher indices of multiple deprivation than the Waltham Forest average. This suggests that there may be an association between alcohol-related incidents and deprivation.

Figure 4.8 Alcohol-related incidents by ward, July 2010–June 2011



Street drinkers

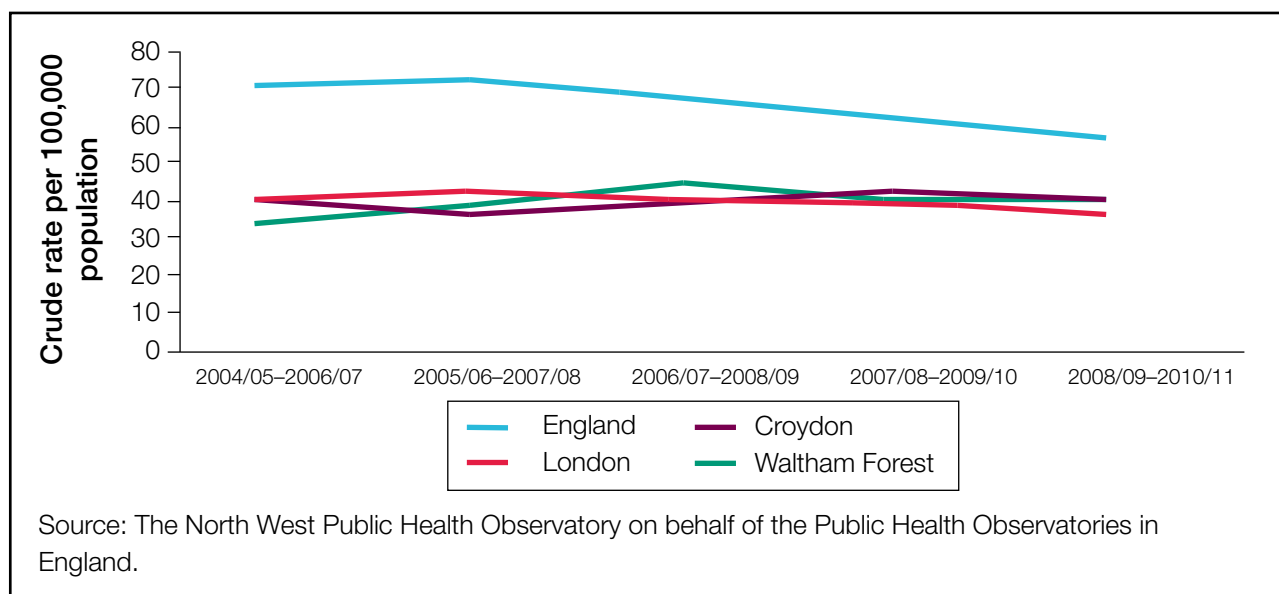
The Alcohol demographic report showed that QALB made 72 contacts from street drinkers in Waltham Forest. Of these:

- 85% were males and 15% females
- Just over a third (32%) were white British, followed by 13% others; 8% other Asian; Caribbean 4%; white Irish 4%; Indian 2%; Pakistani 2%; other mixed 1%; not stated 4%
- 71% were screened assessed and referred to specialist treatment
- 21% refused treatment
- 4% no contact
- 2% escorted to rehabilitation
- 2% moved away.

Alcohol consumption among children and young people

Figure 4.9 illustrates that alcohol-specific hospital admissions for under 18s have remained broadly level in recent years, close to the Croydon and London figures. They remain below the England figures which have declined in recent years.

Figure 4.9 Three-year hospital admissions for alcohol specific conditions, 0 to 17-year-olds Waltham Forest



In total 111 young people (under 18 years) were recorded as being in specialist treatment in 2012/13 for substance misuse, including 31% female and 69% males. Alcohol misuse accounted for 5% of the young people in treatment. Cannabis and alcohol misuse combined accounted for 34%⁷³. It would be interesting to explore the relationship between alcohol and cannabis usage among young people. This may help to identify effective interventions to reduce the usage of alcohol and cannabis combined among this cohort.

The white British ethnic group was the largest group accessing treatment. There is significant under representation of young people from black and Asian backgrounds compared to school population numbers in these groups⁷⁴.

A UK study conducted by Joseph Rowntree Foundation found that⁷⁵:

- 70% of Year 9 students and 89% of Year 11 students in England have had an alcoholic drink
- The most common age for a first drink was 12 to 13; usually when with an adult and celebrating a special occasion
- Year 9 students are most likely to have been drinking alcopops, beer or lager. By Year 11, students are most likely to drink beer, lager, spirits or liqueurs. In both year groups, those drinking beer and lager are consuming much larger quantities of these drinks than any other type of drink.

⁷³ Young people's substance misuse needs assessment 2011.

⁷⁴ Waltham Forest JSNA 2010/11.

⁷⁵ Joseph Rowntree Foundation (2011): Young People, Alcohol and Influence, <http://www.jrf.org.uk/sites/files/jrf/young-people-alcohol-summary.pdf>

Lesbian, gay, bisexual and transgender (LGBT) and alcohol

Results from a number of small studies in the UK suggest that there are higher levels of alcohol misuse among lesbian, gay and bisexual people.

The London Health Improvement Board (LHIB)

LHIB has identified alcohol harm reduction as a priority for London. As part of this priority, LHIB recommends the following focusing on the following areas:

- **Vision and partnership** – how we want to position alcohol in London working in partnership with public and private sector partners to help deliver the alcohol priority, and bringing together a guiding coalition to help address the problems local authorities and NHS face from alcohol misuse
- **Licensing and enforcement** – working with the licensed trade to encourage more effective self-regulation and improvement
- **Early intervention** – Working across London to encourage and improve the use of IBA, and to better connect early interventions with treatment pathways.

What are effective interventions?

To date, national guidance and much research on the effectiveness of treatments for alcohol misuse has been provided in separate documents, notably:

- Routes to recovering via community: mapping user manual (PHE 2013)
- Commissioning treatment for dependence on prescribed and over-the-counter medicines: a guide for NHS and local authority commissioners (PHE, 2013)
- The National Institute for Health and Care Excellence has also produced separate guidance documents for drug misuse, alcohol misuse and lifestyle interventions⁷⁶.

The evidence on which these documents are based is broadly summarised as follows.

Alcohol treatment

The Review of the Effectiveness of Treatment for Alcohol Problems⁷⁷ demonstrates there are a range of effective treatments to suit the variety of potential service users, with evidence indicating that cognitive behavioural approaches offer the best chance of success.

A model of care for alcohol misusers (National Treatment Agency for Substance Misuse (NTA), 2006) previously provided best practice guidance for individual treatment, prior to the release of NICE Guidance documents and the new National Drug Strategy (Home Office, 2010).

The most appropriate intervention recommended for dependent drinkers is structured psychosocial intervention with inpatient or community detoxification if also required. Wraparound care, including help with e.g. family support, housing and employment is recommended by the most recent national Drug Strategy (Home Office, 2010) following the results of pilots.

A number of individual face-to-face interventions, such as counselling and motivational interviewing, have been evaluated for their effectiveness in addressing harmful drinking or drug use. There is good evidence that motivational interviewing approaches are effective in a treatment context⁷⁸.

⁷⁶ <http://www.nice.org.uk/nicemedia/live/11813/36009/36009.pdf>

⁷⁷ Raistrick *et al.*, 2006.

⁷⁸ Rubak S., Sandbaek A., Lauritzen B. and Christensen B. (2005). Motivational Interviewing: a systematic review and meta-analysis. *British Journal of General Practice* 55 (513), 305-312.

Combined drug and alcohol treatment services

Evidence shows that drug and alcohol misuse often co-exist in drug users. Clients can transfer from misusing one substance to misusing another if the underlying causes of addiction are not addressed. To achieve sustained recovery from dependency on drugs and alcohol together or either alone, it is essential to address client's needs for psychosocial or practical support.

The Government's new drug strategy (2010) has resulted in the removal of the barrier to NTA funding being used for the treatment of dependent drinkers (who are not using drugs). As a result of this, it is no longer necessary to commission services providing separate addiction treatment for people dependent on drugs and for people dependent on alcohol. This gives an opportunity to commission integrated drug and alcohol treatment services, which local commissioners, service providers and service users have previously recommended as an approach that works.

Best practice in lifestyle interventions

Identification and Brief Advice (IBA) is an effective evidence-based intervention to raise awareness of risk: and will reduce alcohol use to low risk levels in one in eight increasing risk or higher risk drinkers. In addition, dependent higher risk drinkers will be identified and can be referred into services to help them to address this problem drinking. Opportunistic use of IBA is justifiable when a high proportion of the population are drinking in excess of low risk levels.

Implementation of a general 'lifestyle' approach to delivering IBA interventions on a population basis will achieve population-scale reduction in drinking at increasing risk and higher risk levels. Attention to 'what works' in lifestyle interventions is therefore also relevant: always recognising that this is an area that spans 'prevention' and 'treatment', and as such, will not be the responsibility of the Drug and Alcohol Treatment services alone to provide.

IBA in community pharmacy

Evidence suggests that IBA services delivered through community pharmacies is an effective way of raising awareness of alcohol risks with large numbers of people, including those who are not regular users of other health services⁷⁹.

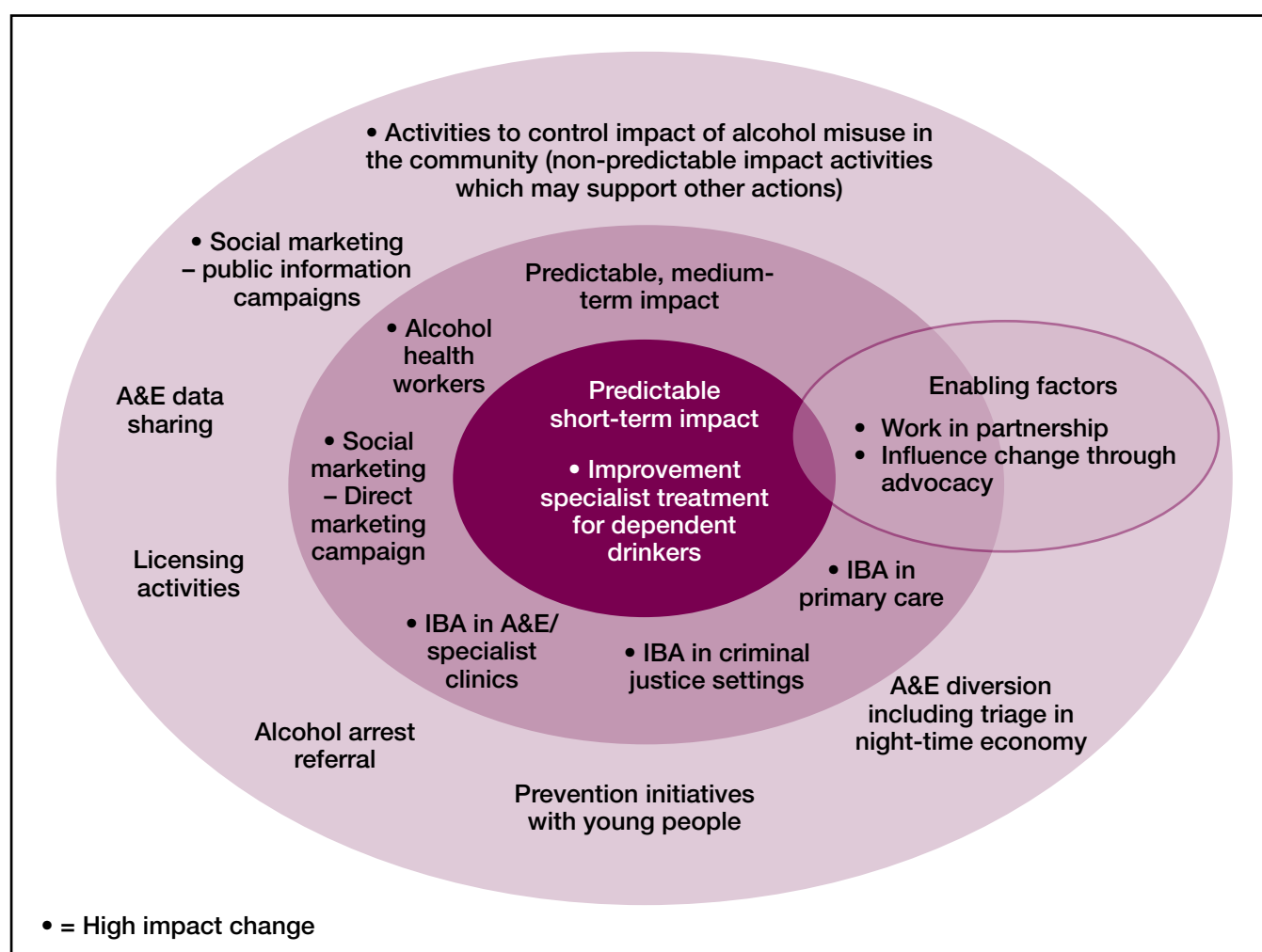
Community strategies to reduce substance misuse

A range of teams within local authorities may be involved in fulfilling the local authority's duty to combat the misuse of drugs and alcohol, including community safety teams: licensing teams: children and youth services: neighbourhood teams: and town centre management teams. Several community-based programmes have shown promising results in reducing hazardous alcohol consumption amongst young people and adults⁸⁰. These programmes may include increased enforcement of licensing and underage alcohol sales legislation, other restrictions on alcohol sales, and community events to reinforce messages regarding alcohol consumption. Programmes which combine education in schools with parental and community involvement may be particularly promising. Community-based universal approaches have been less explored for illegal drug use, due to the relatively lower prevalence of the latter compared to excessive drinking.

Evidence-based high impact changes have been recommended by the Department of Health to reduce hospital admissions for alcohol-related harm see Figure 4.10.

⁷⁹ Health Committee – The Government's Alcohol Strategy Written evidence from Pharmacy Voice July 2012.

⁸⁰ Foxcroft D., Ireland D., Lowe G., Breen R. (2002) Primary Prevention for Alcohol Misuse in Young People Cochrane database of systematic reviews, issue 3. ALSO Holder H., Gruenewald P., Ponicki W., Treno A., Grube J., Salz R., Voas R., Reynolds R., Davis J., Sanchez L., Gaumont G. and Roper P. (2000) Effect of Community-based interventions on high risk drinking and alcohol-related injuries Journal of the American Medical Association 284(18) 2341-2344.

Figure 4.10 Related impact on alcohol-related hospital admissions

Family-focused strategies to reduce substance misuse

Parental substance misuse clusters with other risk factors, notably deprivation, offending, mental ill health and domestic abuse. Together these impact on family functioning and outcomes for children and young people. Parental substance misuse is identified as a key reason for children needing specialist children's services. There is some debate about the extent of this hidden problem⁸¹, however, the Department of Education report that it accounts for 34% of long-term cases and in some areas of the UK up to 60–70% of all care proceedings⁸².

Understanding substance misuse in the context of the family (taking a 'Think Family' approach), has been increasingly identified as a means to reduce the risk of harm to children. It has also been identified as a key protective factor that can support recovery⁸³.

⁸¹ ACMD (2003) 'Hidden Harm' <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Good%20Practice/hiddenharm.pdf> accessed 21/03/12.

⁸² <http://www.education.gov.uk/childrenandyoungpeople/families/childrenincare/a0069857/evidence-based-intervention>.

⁸³ ACMD (2003) 'Hidden Harm' <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Good%20Practice/hiddenharm.pdf> accessed 21/03/12.

School-based education and advice

Overall, school-based alcohol interventions were found to be cost effective, given the fact that they may avert the high costs associated with harmful drinking (both in terms of health and other consequences). Intensive long-term programmes may not be cost effective (NICE, 2007a). Alcohol education incorporated into the science and PSHE (personal, social and health education) curriculum is unlikely to generate any significant additional costs. Benefits would include reductions in alcohol-related missed schooling, teenage conceptions and anti-social behaviour and crime⁸⁴.

Multi-component programmes – street drinkers

Evidence suggests that enforcement is necessary but not sufficient, in that it is unable to address the causes of unlawful or excessive demand for alcohol. In order to be effective in reducing alcohol-related harms, law enforcement and regulation works best when embedded within community focused multi-component programmes that encompass broader approaches to harm reduction⁸⁵. Therefore embedding enforcement with community outreach service could be an effective intervention to engage with street drinkers to reduce alcohol-related harms.

The Alcohol Academy briefing 2009⁸⁶ suggested supporting actions should be delivered through effective multi-agency working whereby outreach and support services work in partnership with enforcement agencies. A study in Hounslow⁸⁷ recommends that the most effective way to deal with public drinking is through a combination of enforcement, changes to the physical environment and access to both treatment and social services.

Addressing availability of alcohol

Evidence suggests that regulating production and distribution of alcoholic beverages is an effective strategy to reduce harmful use of alcohol. Many countries have restrictions on the sale of alcohol covering age of consumers and on licensing, with limits on hours and days of sale and regulations on vendors and the density of outlets⁸⁸.

The Government's Alcohol Strategy⁸⁹ recommends self-regulation and proactive initiatives, driven by the licensed trade in partnership with the police and local authorities. In particular, licensed premises receiving Best Bar None accreditation; town and city centres achieving Purple Flag status; and Business Improvement Districts are good examples of what can be achieved.

What is being done locally to address alcohol misuse?

Review – The Council is reviewing current alcohol treatment services. There is a need to target those most at risk, under-represented groups and treatment-naïve individuals by addressing early identification, screening, treatment and management including recovering.

⁸⁴ Liverpool Public Health Observatory (2010): Prevention Programmes, Cost-Effectiveness Review: Alcohol- http://www.liv.ac.uk/PublicHealth/obs/publications/report/84_alcohol_cost_effectiveness_FOR_WEBSITE.pdf

⁸⁵ Hadfield P and Measham (2011); Lost Orders?: Law Enforcement and Alcohol in England and Wales; <http://www.portmangroup.org.uk/assets/documents/Law%20Enforcement%20and%20Alcohol%20in%20England%20and%20Wales%202011%20Executive%20Summary.pdf>

⁸⁶ Alcohol Academy Briefing, 2009 <http://www.alcoholacademy.net/uploads/Alcohol%20Academy%20briefing%201%20Street%20drinking%20enforcement%20Vs%20support.pdf>

⁸⁷ Street Drinking in Hounslow 2005: <http://policeauthority.org/Metropolitan/downloads/partnerships/cdrp/hounslow-streetdrinking.pdf>

⁸⁸ Liverpool Public Health Observatory (2009): Reducing emergency alcohol-related hospital admissions: http://www.liv.ac.uk/PublicHealth/obs/publications/report/77_LATEST_DRAFT_-_Alcohol_and_demand_management_Oct_09.pdf

⁸⁹ The Government's Alcohol strategy: <http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy?view=Binary>

Substance misuse health needs assessment and service review have been undertaken to inform commissioning strategy.

Business as usual – For those with substance misuse problems, specialist services commissioned include open access services for drug and alcohol users with referral to more structured interventions, outreach services providing information, advice and referral to services, specialist structured intervention, counselling services for BAME groups with specialist outreach work, crisis intervention, community detoxification and residential rehabilitation and young people's substance misuse services.

There are a range of specialist alcohol treatment services for adults and young people, including a residential service commissioned in Waltham Forest which links into the drugs services provided under the umbrella of substance misuse services.

Two Alcohol Liaison Nurses have been in post – to provide brief interventions to patients in the form of motivational interviewing, with the intention of enabling patients to reduce hazardous and harmful drinking. Where appropriate the Alcohol Liaison Nurse conducts triage assessments and makes referrals to appropriate specialist services. However, much of this role has been ward-based due to front-end A&E systems not being geared to identifying increasing and higher risk drinkers and therefore needs to be reviewed.

In Waltham Forest there is street drinkers enforcement intervention known as Designated Public Places Orders (DPPOs) in place. There are currently two Alcohol Restriction Zones in Waltham Forest:

- Walthamstow Town Centre
- Leytonstone High Road area.

Evidence that we are making a difference

Progress since last year's alcohol JSNA

Recommendations JSNA 2012/13	Progress
Review current Alcohol Liaison Nurse post to include case finding and deliver IBA, medical management of patients with alcohol problems; liaison with community alcohol and other specialist services; education and support for other healthcare workers in the hospital. The Frequent Attenders model and subsequent A&E alcohol pathway for responding to those patients with the most alcohol-related A&E attendances would also be included in this review.	Two Alcohol Liaison Nurses are in post – one covers hospital wards and the other A&E. Psychiatric Liaison Collaborative Task and Finish Group in place, and currently working towards developing Rapid Assessment. Interface Discharge (RAID) model. Integrated alcohol service currently working with Whipps Cross colleagues and looking at care plans and frequent flyers).
Reconfiguration of the Community Alcohol Treatment services within existing North East London Foundation Trust (NELFT) and Turning Point contracts so that all community-based modalities are delivered from one location, i.e. a fully integrated community detox and psychosocial interventions programme. Will include clear pathways between hospital, primary care, young people community specialist services and drug treatment services and the probation service.	Alcohol Integrated service in place. Clear pathway between A&E and community service. Currently development of joint protocols to look at care pathway and discharge issues: <ul style="list-style-type: none"> • Referrals pathways – in and out. • Protocol for referral. • Response time for referral.

Recommendations JSNA 2012/13	Progress
Review the current Direct Enhanced Service (DES) for identification and brief advice in primary care. Consideration should be given to extending the DES to cover all at-risk groups including over 40s coming via NHS health checks. Explore the feasibility with the CCG.	NHS health checks in place. DES moved to CCG. IBA training provided within Primary care. NELFT Integrated Alcohol Service Consultant Psychiatrist currently visiting and in discussion with GP practices across the borough.
Explore the possibility of incorporating school-based alcohol interventions into the Waltham Forest Healthy Schools Programme.	IBA training provided to the Waltham Forest Healthy Schools Programme lead.
Further develop the multi-agency Street Drinking Taskforce within existing QALB contractual obligations.	Waltham Forest street drinkers meeting still in place, attending by QALB. QALB has established good links with community safety police.
Refresh the current Waltham Forest Alcohol Strategy and implement via the Waltham Forest Alcohol Strategy Group.	Substance misuse steering group has been formed which will progress this in 2013/14.
Stimulate referral pathways from Primary Care into structured treatment via GP Targeted Promotion.	Promotional work is being carried out by commissioned treatment providers (Community Drug and Alcohol Services (CDAT) and Turning Point) through awareness training within primary care.

What is the perspective of the public on support available to them?

Start To Access Recovery Service (STARS) is a user-led group for people with drug and alcohol problems run by volunteers, who have experienced the problems themselves. They contribute to the commissioning cycle by sharing their experiences of treatment with commissioners. They also provide peer support and social activities for those who have completed treatment.

What are the priorities for improvement over the next five years?

- Re-commission substance (alcohol and drugs) misuse services in Waltham Forest
- Refresh the current Waltham Forest Alcohol Strategy and implement via the Waltham Forest Alcohol Strategy Group
- Embedding IBA in frontline staff as part of their initial assessment process. This will help to reduce alcohol use to low risk level
- Full analysis of alcohol-related hospital admissions in Waltham Forest is undertaken to establish which particular groups need to be targeted
- Review current alcohol treatment pathway to include prevention, early intervention, treatment and recovery
- Commission IBA from the Community Pharmacies particularly, those already delivering needle exchange and share care consumption services. IBA services delivered through community pharmacies are an effective way of raising awareness of alcohol risks with large numbers of people, including those who are not regular users of other health services

- Embedding school-based substance misuse education and interventions into the Waltham Forest school nurses programme
- Greater utilisation of outreach and safer neighbourhood services to identify street drinking hotspots to refer into appropriate services
- The Local Development Plan includes conservation of pubs as a priority to conserve historic buildings. Work with Planning and Policy to develop a scheme that would work within this to ensure that pubs are social meeting places that control drinking levels and explore Licensing/Public health initiatives such All Bar None and Purple Flag
- Develop a clear pathway to include health promotion outreach service to Designated Public Places Orders (street drinkers enforcement intervention) to ensure that there are effective multi component interventions to engage with street drinkers to reduce alcohol-related harms in Waltham Forest. Targeting E17 which is known to be a hotspot (Market Square and Coronation Gardens) for problematic street drinkers
- Undertake a literature review to explore the relationship between alcohol and cannabis combined usage among young people
- Stimulate referral pathways from Primary Care into structured treatment via GP Targeted Promotion.

4.3 Substance misuse

Executive summary

About a third of the UK population admit to taking drugs at some stage in their lives, but few people go on to develop problems. According to research endorsed by the Home Office, problem drug use costs society £15.4 billion a year, of which £13.9 billion is attributed to crime committed by drug dependent offenders.

It is estimated that in Waltham Forest, the number of people aged 16–59 using drugs are as follows: class A; 14,765 any drugs; 11,409 cannabis. There are about 1,463 people aged 15 to 64 classified as OCUs (opiate and/or crack cocaine users) in Waltham Forest.

Three wards in the borough accounted for 28.1% of all drugs recorded offences in the borough. High Street ward 12.3%; Forest 8.8% and Hoe Street 7.0%. These three wards are in the top 21% of all wards across the Metropolitan Police Service.

492 new referrals were made into the treatment system in 2011/12. Overall there were 1,206 clients in treatment with 8% of those clients having been in the treatment system between two and four years and over 5% for over four years. 467 clients exited the treatment system which accounts for about 39% of those in treatment during the year.

It is also estimated that Waltham Forest had 267 adult opiate clients and 188 adult non-opiate clients in treatment per 100,000 population.

There were on average about 95 opiate users each year successfully completing treatment services between 2010 and 2012. 21% (20) re-presented into the treatment services. The proportion of Waltham Forest opiate users re-presenting to the treatment services was higher than the cluster average between 2011 and 2012.

There were on average about 203 non-opiate users each year successfully completing treatment services between 2010 and 2012. Of these, 6% (12) re-presented into the treatment services. The proportion of Waltham Forest non-opiate users re-presenting to the treatment services was lower than the cluster average between 2010 and 2012.

To date, national guidance and much research on the effectiveness of treatments for drug and alcohol misuse has been provided to support recovery process.

‘Start To Access Recovery Service’ (STARS) is a user-led group for people with drug and alcohol problems run by volunteers, who have experienced the problems themselves.

We are working hard to ensure our local treatment system is more recovery focused and that our treatment system is integrated with support services that will optimise treatment gains and support users to build ‘recovery capital’ to sustain their recovery

Recommendations

Commissioning

- Re-commission substance (alcohol and drugs) misuse services in Waltham Forest.

Prevention and early intervention

- Increase drug awareness training through frontlines staff
- Engage community-based generic services (tier 1) to identify signs of substance misuse
- Ensure substance misuse is incorporated into any health promotion work in schools, colleges including Pupil Referral Units and alternative provisions
- Ensure wider coverage and better uptake of blood borne viruses screening and immunisation.

Treatment system

- Improve recovery focus stepped approaches which does not focus solely on abstinence
- Increase access to GP Shared Care and primary care services for more stable service users
- Increase access to Employment, Training, Education to ensure clients have access to supported housing and encourage diversionary activities which steer clients away from substance misuse such as sport, art, music etc
- Increased partnership and promotion work to develop stronger links between community-based generic services to reinforce and strengthen recovery support and lessen the risks of relapse
- Ensure all staff across all sectors, who regularly come into contact with clients with substance misuse or dual diagnosis (mental health and substance misuse), have the appropriate training and support relevant to meet their needs
- Commissioners to develop robust performance management systems to ensure effective monitoring of the treatment services
- Investigate reasons behind lack of engagement with treatment system particularly high attrition rate in criminal justice through service users involvement
- Robust mobile care planning across treatment system partnership
- Continue to support successful completion of treatment and ensure that re-presentations are minimised by implementing robust aftercare and recovery arrangements within each service.

Policy context

About a third of the UK population admit to taking drugs at some stage in their lives, but few people go on to develop problems. There are an estimated 320,000 heroin and crack cocaine users in England and an unknown number of other people whose misuse of dangerous drugs poses problems not only for themselves but also for society. Almost 1.5 million adults are significantly affected by a family member's illegal drug use.

According to research endorsed by the Home Office, problem drug use costs society £15.4 billion a year, of which £13.9 billion is attributed to crime committed by drug dependent offenders.

What is drugs misuse?

The World Health Organisation defines the misuse of drug or alcohol as the use of a substance for a purpose not consistent with legal or medical guidelines. It can also be defined as a pattern of substance use that increases the risk of harmful consequences for the user. Some would limit the consequences to physical and mental health (as in harmful use); some would also include social consequences.⁹⁰

⁹⁰ Lexicon of alcohol and drug terms, World Health Organization, Geneva 1994.

Drug user categorisation

A crack user who had not used opiates would be a non-opiate user and the same for all other users. The user group for drug treatment service is categorised into opiate and non-opiate users.

Local picture – adults

Prevalence estimates of drug use in Waltham Forest

Evidence suggests, nationally⁹¹:

- 3.0% of the population aged 16 to 59 years had used a class A drug (see Table 4.2) in 2009/10
- 8.8% of the population aged 16 to 59 years had used any illicit drug in 2009/10
- 6.8% of the population aged 16 to 59 years had used cannabis in 2009/10 (see Table 4.1)

Applying this to Waltham Forest, it is estimated that: (see Table 4.1).

Table 4.1 Estimates of drug use in Waltham Forest

	Population (16-59)	Number of population using class A drug	Number of the population using any drug	Number of the population using cannabis
Waltham Forest	67,782	5,033	14,765	11,409

Table 4.2 Classification of drugs under the Misuse of Drugs Act

Classification	Drug
Class A	Crack cocaine, cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, methamphetamine (crystal meth).
Class B	Amphetamines, barbiturates, cannabis, codeine, methylphenidate (Ritalin), synthetic cannabinoids, synthetic cathinones (eg mephedrone, methoxetamine).
Class C	Anabolic steroids, benzodiazepines (diazepam), gamma hydroxybutyrate (GHB), gamma-butyrolactone (GBL), ketamine, piperazines (BZP).

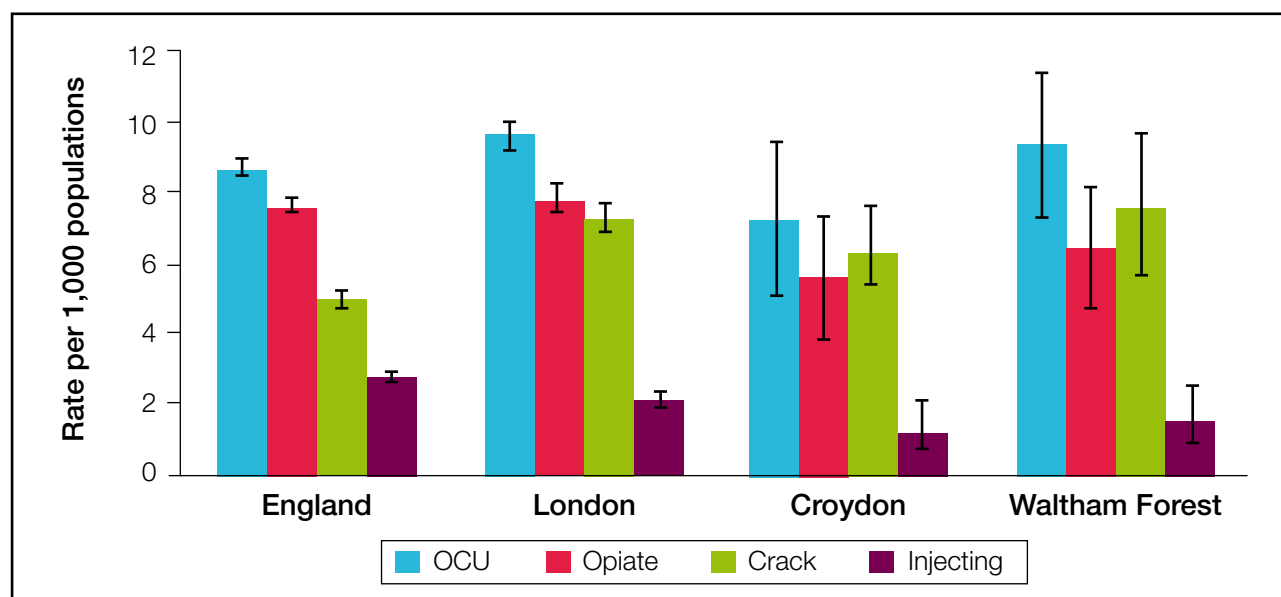
Prevalence estimates of OCUs (opiates and crack users) in Waltham Forest

There are about 1,463 people aged 15 to 64 classified as OCUs in Waltham Forest⁹². Expressing this as a rate, equates to about nine OCU users in every 1,000 adults (16 to 64) in Waltham Forest.

Figure 4.11 shows that the prevalence of OCUs and separate opiate users in Waltham Forest is slightly lower than London, but slightly higher than England and higher than Croydon. The differences between Waltham Forest and its comparators are not statistically significant. The prevalence of separate crack users in Waltham Forest is significantly higher than England but not different from London and Croydon. Compared to England, Waltham Forest has a lower prevalence of injecting drug users but differences are not statistically different from London and Croydon. There is a need to target injecting drug users to reduce the spread of blood borne viruses. This is also emphasised by the Drug Treatment Outcomes Research Study.

⁹¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/116333/hosb1211.pdf

⁹² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/116333/hosb1211.pdf

Figure 4.11 Estimated prevalence of OCU in Waltham Forest aged 15 to 64, 2010/11

Drug-related offending

Police data

Drugs offences make up 6% of all total notifiable offences. However, it should be noted that drugs offences recorded by the police are not an indication of the level of drug-related problems in an area but more an indication of the number of police operations undertaken to tackle drugs. There were 1,486 drugs offences recorded by police in Waltham Forest between April 2012 to March 2013, compared to the 1,076 offences recorded between August 2011 and July 2012. This is a 27.6% increase from the same period the previous year. Three wards in the borough accounted for 28.1% of all drugs recorded offences in the borough. High Street ward 12.3%; Forest 8.8% and Hoe Street 7%. These three wards are in the top 21% of all wards across the Metropolitan Police Service⁹³.

Drug Intervention Programme

The Drug Intervention Programme (DIP) was introduced in April 2003 with the aim of developing and integrating measures for directing adult drug-misusing offenders into drug treatment and reducing offending behaviour. As Waltham Forest is a DIP intensive borough, this requires compulsory class A drug testing upon arrest for trigger offences.

DIP data from the London Analyst Support⁹⁴ Site has been analysed to show all those being tested upon arrest at Chingford Police Station and also where Waltham Forest resident arrestees were tested across London. The data for Waltham Forest residents tested upon arrest across London between April 2012 and March 2013 revealed where their offences occurred:

- 57.9% Waltham Forest
- 15.8% Redbridge
- 26.3% Haringey, Croydon, Greenwich, Ealing and Westminster.

⁹³ Drugs Intervention Programme data 2012/13.

⁹⁴ *Ibid.*

In contrast the borough of residence of people who are tested upon arrest at Chingford Police Station reveals who is committing drug-related crime within Waltham Forest:

- 53.8% Waltham Forest residents
- 23% Newham
- 46% Redbridge, Enfield and Haringey.

This tallies with data which show that people travel relatively short distances to commit crimes. It also shows that offenders from Newham come to Waltham Forest to offend, but offenders from Waltham Forest do not go to Newham to commit trigger offences.

Table 4.3 shows the top three offences for those being tested upon arrest within Waltham Forest, to identify if there are any different offending patterns that attract offenders to Waltham Forest.

Table 4.3 Top three offences for those being tested upon arrest within Waltham Forest

Borough of residence	1st	2nd	3rd
Waltham Forest	Theft (41.2%)	Burglary (10.5%)	Possession Class A (8.5%)
Newham	Theft (31%)	Burglary (15.3%)	Non-trigger offence (14.3%)
Haringey	Theft (35.4%)	Burglary (14.1%)	Non-trigger offence (11.7%)
Redbridge	Theft (32.4%)	Burglary (15.8%)	Non-trigger offence (10%)

This breakdown of class A drugs for those all offenders testing positive is:

- Cocaine 16.3%
- Both cocaine and opiates 14.4%
- Opiates 0.3%.

For Waltham Forest residents the break down is:

- Cocaine 50.8%
- Both cocaine and opiates 32.8%
- Opiates 16.4%.

Within Waltham Forest, proportions of males and females who tested positive upon arrest were 17.7% females compared to 82.3% males.

62% of those testing positive were of white European appearance, compared with only 19.4% of those of African Caribbean appearance. For white European, African Caribbean and Asian arrestees, the main drug that they tested positive for was cocaine.

The peak age for people to test positive was 18 to 32, accounting for 68% of all those testing positive.

The offences committed with the greatest percentage of people testing positive on arrest were:

- Theft 48.1%
- Drugs 20.5%
- Non-trigger offence 11.5%

Despite increasing acquisitive crime levels across the borough, the proportion of people testing positive upon arrest remains stable.

Blood Borne Viruses (BBV)

Blood Borne Viruses services for drug users, particularly vaccination for hepatitis B and testing for hepatitis C has improved due to improved service delivery across the drug treatment partnership. However, much more needs to be done to improve testing for those outside the drug treatment services who belong to the at risk group.

For more information, please see Chapter 7.3.

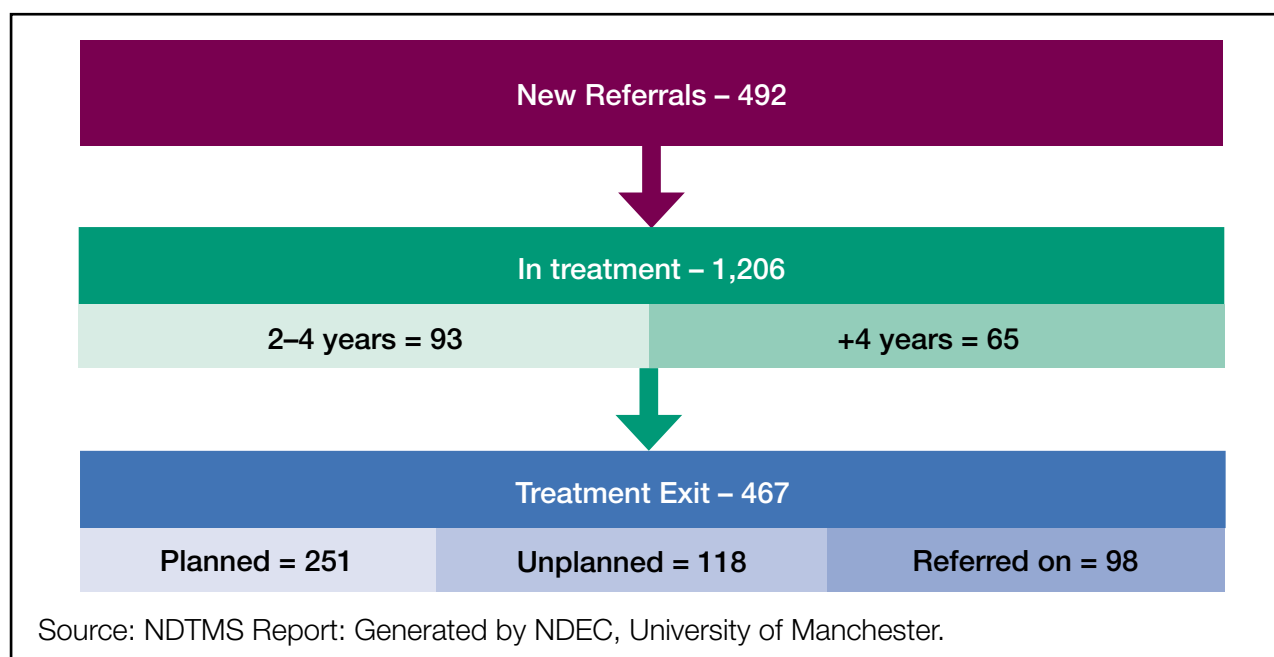
Needle and Syringe Programme

In terms of harm reduction and reducing BBV syringe/needle exchange services are vital. There are currently eight community pharmacies and two treatment providers providing the needle exchange services.

Drug Treatment System

Figure 4.12 shows a summary of numbers referred into the treatment system in 2012/13 financial year. 492 new referrals were made into the system. Overall there were 1,206 clients in treatment with 8% of those clients having been in the treatment system between two and four years and over 5% for over four years. 467 clients exited the treatment system which accounts for about 39% of those in treatment during the year.

Figure 4.12 Referral routes to the treatment system



Opiate and non-opiate clients in the treatment system

Table 4.4 shows breakdown of number of opiate and non-opiate clients in the treatment services in Waltham Forest between 2010/11 and 2012/13.

Table 4.4 Breakdown of opiate and non-opiate clients in treatment services

	2010/11	2011/12	2012/13
Opiate	525	536	518
Non-opiate	460	347	304
Totals	985	883	822

Source: NDTMS Report: Generated by NDEC, University of Manchester.

It is also estimated that Waltham Forest had 267 adult opiate clients and 188 adult non-opiate clients in treatment per 100,000 populations. This is to suggest that in every 100,000 adult populations in Waltham Forest, there is likely about 455 of them in the drug treatment service see Table 4.5.

Table 4.5 Adults in drug treatment service

Types of drug use	Average annual number of users	% of users	Crude rate per 100,000
Opiate	526	59%	267
Non-opiate	370	41%	188
Totals	897	100%	455

Source: NDTMS Report: Generated by NDEC, University of Manchester.

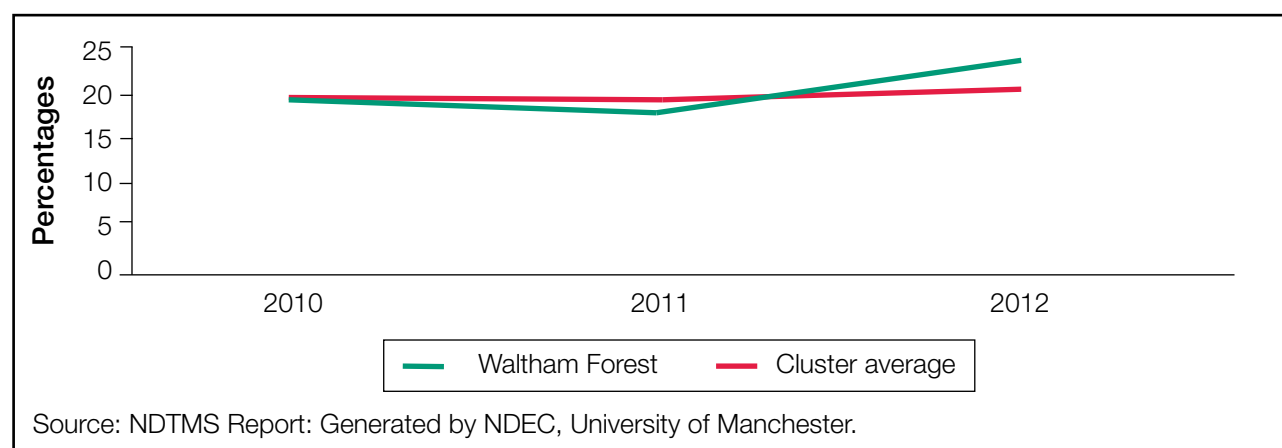
Re-presentation to treatment services

Re-presentation is defined as someone who has re-entered the treatment service within six months of treatment after they have successfully completed their treatment. Re-presentation rates are a key measure of whether our treatment system delivers recovery successfully.⁹⁵

Opiate users and re-presentation

There were on average about 95 opiate users each year who successfully completed treatment between 2010 and 2012. Of the 95, 21% (20) re-presented. Opiate users in Waltham Forest re-presenting to treatment services have gone up from 20% (17) in 2010 to 24% (28) in 2012 to 24% (28) in 2012. This was higher than the cluster average between 2011 and 2012 see Figure 4.13.

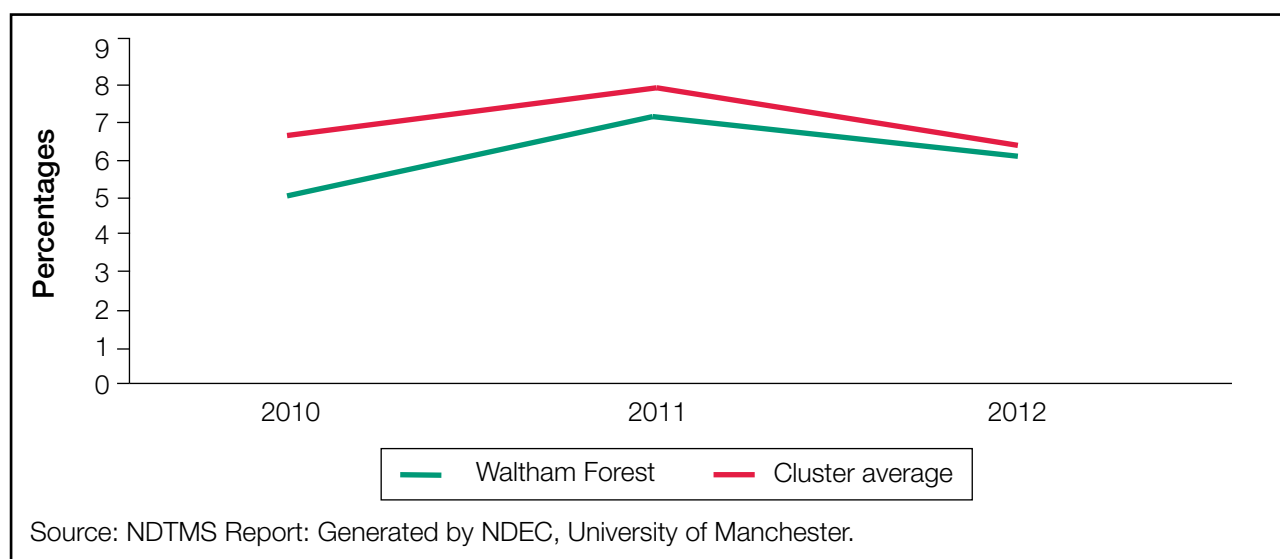
Figure 4.13 Re-presentation by opiate clients, 2010/11 to 2012/13



Non-opiate clients and re-presentation

There were on average about 203 non-opiate users each year from 2010 to 2012 who successfully completed treatment services. Of these, 6% (12) re-presented into the treatment services. Non-opiate users in Waltham who were re-presenting to the treatment services have gone up by 22% (14) from 5% in 2010 to 6% (9) in 2012. Waltham Forest non-opiate users representing to the treatment services was lower than the cluster average between 2010 and 2012 see Figure 4.14.

⁹⁵ National Treatment Agency.

Figure 4.14 Re-presentation by non-opiate clients, 2010 to 2012

Drug related deaths (DRD)

The National Treatment Agency for Substance Misuse (NTA) defines drug-related deaths as 'death where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances controlled under the Misuse of Drugs Act (1971) are involved'.

According to the NTA there were less than 10 DRDs in Waltham Forest in 2011 which was lower than Croydon.⁹⁶

Mental health (dual diagnosis)

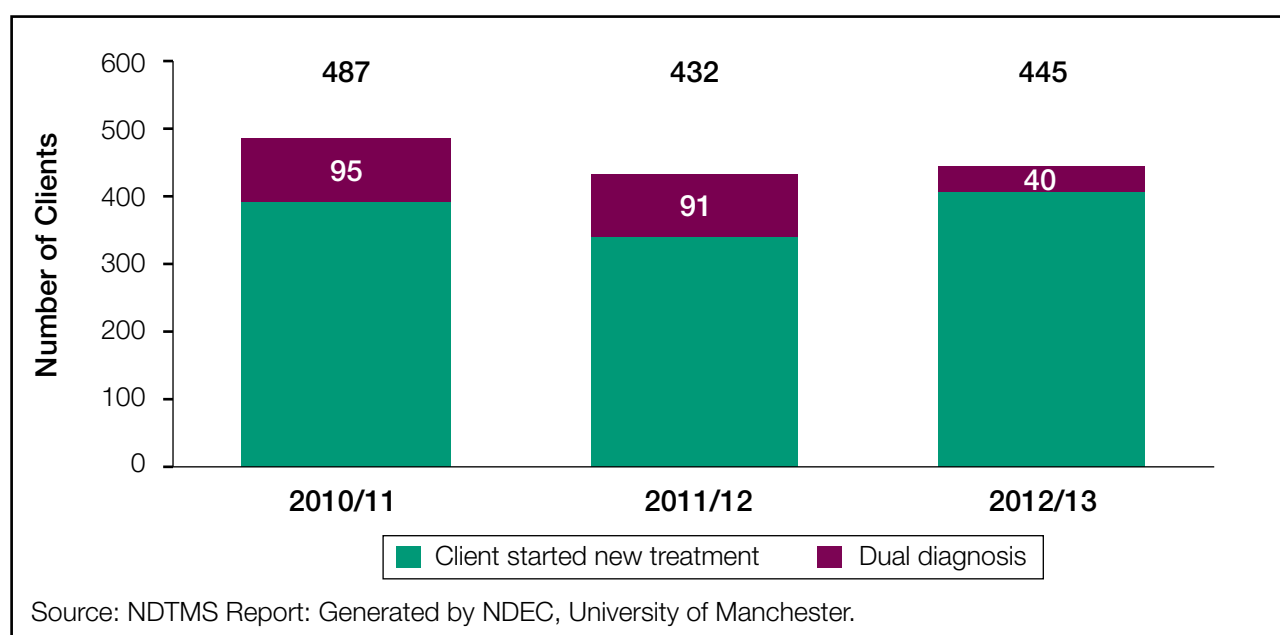
The term 'dual diagnosis' covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently.⁹⁷ The nature of the relationship between these two conditions is complex. Possible mechanisms include:

- a primary psychiatric illness precipitating or leading to substance misuse
- substance misuse worsening or altering the course of a psychiatric illness
- intoxication and/or substance dependence leading to psychological symptoms
- substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses.

Figure 4.15 shows that 445 new clients started their treatment journey (new admissions) in 2012/13. Of these, 40 (9%) of them were dual diagnosis. The number of dual diagnosis have decreased by 11% from 20% (95/485) in 2010/11 to 9% (40/445) in 2012/13.

⁹⁶ Drug-related deaths in the UK, Annual Report 2012: National Programme on Substance Abuse Deaths, (np-SAD) International Centre for Drug Policy, St George's, University of London, UK.

⁹⁷ <http://www.nmhd.org.uk/silo/files/dual-diagnosis-good-practice-guide.pdf>

Figure 4.15 New treat journey and dual diagnosis, Waltham Forest, 2010/11 – 2012/13

Drug users in treatment who are living with their children

Table 4.6 shows the number of drug users in treatment who live with their children. One in three of the Waltham Forest treatment population (269, 33%) has a child living with them at least some of the time. This is the same as the national average.

Table 4.6 Drug users in treatment living with children, Waltham Forest

	Local	Proportion of treatment population	National	Proportion of treatment population
Drug – adults who live with children	269	33%	64,862	33%

Source: Alcohol and drugs, JSNA support pack WALTHAM FOREST Key data to support planning for effective drugs prevention, treatment and recovery

Young people

111 young people under 18 were recorded in specialist treatment in 2012/13 compared to 82 in 2011/12 and 69 in 2010/11. (Table 1) 14 young people over 18 attended the service. Of all the adults and young people in treatment locally, the percentage of which were young people has increased from 8% to 12%, whilst the national statistic has remained at 9%. This year on year increase has been achieved at a time of a decrease in funding from £216,000 in 2009/10 to £193,000 to £158,664 in 2012/13.

722 continue to work with clients beyond their 18th birthday especially those with a physical disability or mental health issue. The service is equipped to work with young people with dual diagnoses due to the specialist professions within the staff team such as psychiatric nurse and social worker. In addition they also accept clients aged 18 and over as many young people decline going over to adult services and would consequently drop out of treatment. Furthermore CDAT (the Community Drug and Alcohol Team) do not tend to accept clients with cannabis as their primary substance and deal mainly with those that use heroin and crack cocaine. These clients are signposted to Turning Point who deals with those with a low level of substance misuse, predominantly alcohol, many of whom are older. Turning Point offers a day programme which is not really suitable to the needs of 18 to 25-year-olds.

According to the NTA, if a person aged 18 or over has needs that can be best met by a young persons' service, then this would be the most appropriate placement.⁹⁸ The NTA have also suggested creating a new service platform for young adults who are developing more serious substance use problems that do not correspond to existing concepts of 'problem drug use' such as crack and heroin use.

There is a protocol in place for transition of care from young people's substance misuse services to adult services with a professional referral form.

What are the effective interventions?

To date, national guidance and much research on the effectiveness of treatments for drug and alcohol misuse has been provided in separate documents, notably:

- Commissioning for recovery (NTA, 2010)
- Routes to recovering via community: mapping user manual (PHE 2013)
- Medication in Recovery Re-orientating drug dependence treatment (NTA 2012)
- Commissioning treatment for dependence on prescribed and over-the-counter medicines: a guide for NHS and local authority commissioners (PHE, 2013)
- Quality standard for drug use disorder (NICE Quality Standard 23) NICE, 2012
- Drug Misuse and Dependence – UK Guidelines on clinical management 2007
- The National Institute for Health and Care Excellence has also produced separate guidance documents for drug misuse, alcohol misuse and lifestyle interventions.

The evidence on which these documents are based is broadly summarised as follows⁹⁹.

Drug treatment

Drug treatment is effective – The Drug Treatment Outcomes Research Study (DTORS): Baseline Report (Jones *et al.* 2007) highlights the positive outcomes which benefit the individual, their family and society. These include abstinence, reduction in illicit drug use, reduction in criminal activity, lower risk of overdose, the spread of blood borne viruses and better health.

⁹⁸ National Treatment Agency. *Young People's Services*, Essential Elements. (2005).

⁹⁹ <http://www.nice.org.uk/nicemedia/live/11813/36009/36009.pdf>

Gossop (2006) also reviewed the evidence of the effectiveness of drug treatment from the last 30 years¹⁰⁰:

- Pharmacological interventions are shown to have better outcomes in terms of reduced illicit drug use, reduced criminal behaviour and lower levels of HIV risk, and better retention rates have been linked to methadone clients
- Psychological interventions help in terms of greater treatment retention, fewer relapses and reduction in drug use
- Residential rehabilitation has shown positive outcomes in terms of improved rates of abstinence, drug injection and needle sharing
- Needle and Syringe Programmes reduce injecting risk behaviours, public order problems and reduced HIV prevalence
- Complementary therapies have been linked to better attrition.

Drug users in treatment commit fewer crimes (Millar *et al.* 2008) – offences halved when drug users went into treatment, particularly acquisitive crime. For those whose offence triggered a test on arrest, there was a reduction of 61% in follow up offences. They also found a link between positive outcomes and treatment duration.

Combined drug and alcohol treatment services

Evidence shows that drug and alcohol misuse often co-exist in drug users. Clients can transfer from misusing one substance to misusing another if the underlying causes of addiction are not addressed. To achieve sustained recovery from dependency on drugs and alcohol together or either alone, it is essential to address client's needs for psychosocial or practical support.

The government's new drug strategy (2010) has resulted in the removal of the barrier to NTA funding being used for the treatment of dependent drinkers (who are not using drugs). As a result of this, it is no longer necessary to commission services providing separate addiction treatment for people dependent on drugs and for people dependent on alcohol. This gives an opportunity to commission integrated drug and alcohol treatment services, which local commissioners, service providers and service users have previously recommended as an approach that works.

Recovery-orientated ambition for drug users

An interim report has been released by the Expert Group chaired by Professor John Strang to provide guidance on the proper use of medications in aiding recovery from drug dependency. This suggested that there is a strong body of evidence for the effectiveness of Opioid Substitution Treatment (OST) but often insufficient focus on recovery-oriented ambition

From the evidence brought to that expert group of 'what works' for complete and sustained recovery, the twelve steps recommended for immediate action were summarised as follows:

1. Audit the balance between overcoming dependence and reducing harm.
2. Review patients to ensure they have achieved , or are working towards, abstinence – particularly from their problem drugs.
3. Encourage more patients to take opportunities for achieving greater recovery.
4. Ensure that eventual exits from treatment are visible from the outset.
5. Review the continuing benefit of ongoing prescribing to patients.
6. Ensure extra support is available to patients coming off medications, along with rapid re-entry if they relapse.

¹⁰⁰ http://www.nta.nhs.uk/publications/documents/nta_treat_drug_misuse_evidence_effectiveness_2006_rb5.pdf

7. Check treatment is optimised, with appropriate range and intensity of interventions.
8. Support services to improve patients' access to social networks, including families, mutual aid and peer support.
9. Support individuals to improve their social capital through work, volunteering and training opportunities.
10. Ensure keyworkers are competent to deliver a full range of psychosocial interventions.
11. Review, and where necessary improve, the quality of recovery care planning.
12. Sustainability. Work with housing and employment services to maximise local access to both.

Community strategies to reduce substance misuse

A range of teams within local authorities may be involved in fulfilling the local authority's duty to combat the misuse of drugs and alcohol, including community safety teams: Licensing teams: Children and youth services: neighbourhood teams: and town centre management teams. Programmes which combine education in schools with parental and community involvement may be particularly promising.

What evidence is there that we are making a difference?

Review – The London Borough of Waltham Forest is reviewing current drug treatment services. There is a need to target those most at risk and treatment-naïve individuals by addressing early identification, screening, treatment and management including sustained recovery.

Substance misuse health needs assessment and service review have been undertaken to inform commissioning strategy.

Pharmacy-based needle exchange and supervised consumption were reviewed and the findings have been included in the substance misuse needs assessment to inform commissioning strategy. This has led to joint working between the treatment providers and community pharmacies to refer treatment naïve services users into treatment.

Waltham Forest continues to perform very strongly in relation to the Public Health Outcomes Framework indicator of successful completions of drug treatment. They are performing at a much higher rate for opiate clients and at a similar rate for non-opiate clients to the rest of the country. PHE London would welcome the opportunity to share any good practice with other partnerships in the London area¹⁰¹.

What is the perspective of the public on support available to them?

Start To Access Recovery Service (STARS) is a User Led group for people with drug and alcohol problems run by volunteers, who have experienced the problems themselves. They contribute to the commissioning cycle by sharing their experiences of treatment with Commissioners. They also provide Peer Support and social activities for those who have completed treatment.

What more do we need to know?

We are working hard to ensure our local treatment system is more recovery focused and that our treatment system is integrated with support services that will optimise treatment gains and support users to build 'recovery capital' to sustain their recovery.

The overarching pathway, combined with a greater focus on continuous support for clients throughout their treatment/recovery journey has been supported by improvements in interagency working. Although we have a number of services offering different interventions, it is crucial that they work together in the context of a system for the benefit of the service users.

¹⁰¹ *Diagnostic Outcomes monitoring Executive Summary*, Quarter 2, 2013/14.

4.4 Overweight and obesity

Executive summary

Data on overweight and obesity among adults are mainly from the Health Survey for England (HSE). Modelled estimates from the HSE 2006–08 suggest that adult obesity in Waltham Forest is not significantly different from the England average.

Childhood obesity is a major issue nationally and locally. Childhood obesity is measured through the National Child Measurement Programme (NCMP). Waltham Forest has participated in the NCMP since 2006. In Waltham Forest, in 2011/12, 9.6 % of children in reception were obese compared with 11% in London and 9% in England. For Year 6 the recorded weight of obesity in Waltham Forest 23.4%, significantly more than in England (19%) but close to the London figure of 22.4%¹⁰². In Croydon 22.2% of Year 6 children were obese.¹⁰³

The draft strategy document, Healthy Weight – Achieving A Healthy Weight For All in Waltham Forest is a local approach that provides a public health framework to tackle obesity among adults and children in Waltham Forest. The strategy will be delivered through our Healthy Weight Steering Group which is a partnership with NELFT, Clinical Commissioning Group (CCG), Greenwich Leisure Limited, and Local Authority.

Our long-term vision is to provide an environment that enables all our residents to make healthy food choices, to stay physically active and to maintain a healthy weight. The work we do to prevent obesity in pre-school children is crucial to achieving this since prevention is more effective than management.

Recommendations

1. Ensure adequate provision by building on the children weight management service 'Go For It'.
2. Redesign the adult weight management service into a Tier 2 and Tier 3 weight management service.
3. Ensure adequate resources are allocated to the current weight management services so that the service meets NICE guidelines and best practice.
4. Ensure that work relating to limiting the proliferation of fast food outlets contributes to reducing health inequalities and is embedded in new and emerging planning policies of the local authority.
5. Continue to work with the Community Dieticians and Environmental Health to encourage local fast food restaurants to implement the Healthy Catering Commitment.
6. Develop the localised Healthy Schools programme to ensure the Food in Schools work is sustained and there is consistent and accessible health and wellbeing support for pupils, their parents/carers and schools across the borough.
7. Implement School Food Plan to increase uptake of school meals and breakfast clubs.

¹⁰² Child health profile, Waltham Forest, www.chimat.org.uk

¹⁰³ Child health profile, Croydon, www.chimat.org.uk

8. Continue dietetic input into children's centres to ensure consistent, easily accessible advice is available to parents/carers around weaning age and beyond.
9. Ensure that resources are available to support children and parents/carers who are identified as being underweight, overweight and obese following the National Child Measurement Programme.
10. With the change in funding for school sport and monitoring, more competitions should be developed to enable participation by young people in schools.
11. Repeat the Nutrition and Dietetics Service patient survey conducted by the Community Dietetics service in 2013/14 to elicit the views of the adult population regarding local weight management services.

Who is most at risk?

The people who are least active are those at greatest risk of ill health. Increasing the activity levels of adults who are not meeting the recommendations is important and will produce a reduction in chronic disease.

According to research, some sectors of the population are at considerably higher risk of developing obesity, with an associated increase in the incidence and prevalence of related co-morbidities. These groups are:

- Children, for genetic and/or environmental reasons from families where one or both parents are overweight or obese
- Individuals from particular black, asian and minority ethnic (BAME) groups
- When using BMI as a measure, findings suggest that compared to the general population, obesity prevalence is lower among men from black African (17%), Indian (14%), Pakistani (15%) and (6%) Bangladeshi and (6%) Chinese communities, with the highest being from the black Caribbean and Irish communities at 24%.¹⁰⁴ Among women obesity prevalence using BMI appears to be higher for those from black African (38%), black Caribbean (32%) and Pakistani (28%) groups than for women in the general population and lower for women from the Chinese (8%) ethnic group¹⁰⁵
- People living on a low income where, for example 14% of women in social class 1 are obese compared with 28% in social class V
- People who stop smoking
- Older people: increasing age is associated with increasing prevalence in obesity up to the age of 64 years, when a decline in the prevalence begins.

Certain events in life have also been found to be associated with weight gain: pregnancy, menopause and smoking cessation (NICE 2006).¹⁰⁶

More recently, people who use mental health services, in particular those with a diagnosis of schizophrenia or bipolar disorder, have been identified as being at increased risk of greater levels of obesity and associated conditions, such as heart disease and diabetes.¹⁰⁷ In addition to the groups listed above, it is important to also consider the needs of those disadvantaged groups for whom barriers to accessing services are known to exist, including: people with mental health problems, people with a disability and people for whom English is not their first language.

¹⁰⁴ National Obesity Observatory, Obesity and ethnicity January 2011, www.noo.org.uk

¹⁰⁵ National Obesity Observatory, Obesity and ethnicity January 2011, www.noo.org.uk

¹⁰⁶ NICE (2006) Obesity: Full guideline – section 3 Prevention – evidence statements and reviews, NICE.

¹⁰⁷ DH (2006) Choosing Health: Supporting the physical health needs of people with severe mental illness, DH, London.

A link has been established between breastfeeding and obesity in later life. Research suggests that children who are breastfed are less likely to be overweight or obese as they grow up.

There is evidence that weaning earlier than current recommendations leads to rapid weight gain in infancy which may in turn increase the risk of child obesity.¹⁰⁸ Early weaning has also been found to be associated with increased weight and body fat at age 7 years.¹⁰⁹

Local picture

The scale of the problem demands that a population approach is taken to tackle obesity. The issues of obesity, physical activity and healthy eating are already integral to a wide range of local strategies, for example:

- Best Start Life Pilot
- Love Mums (Breastfeeding) Project
- Waltham Forest Best Start in Life Children and Young People Strategy
- Waltham Forest Healthy Child Programme 0 to 5 years
- Waltham Forest Healthy Child Programme 5 to 19 years
- Waltham Forest Healthier Fairer Health Inequalities Strategy
- Action Plans on Coronary Heart Disease, Diabetes, Cancer, Mental Health all highlight the importance of preventing and managing obesity and promoting healthy lifestyles and physical activity
- Joint Strategic Needs Assessment
- Waltham Forest Local Development Framework Core Strategy
- Waltham Forest Hot Food Takeaway Supplementary Planning Document
- Waltham Forest Catering School Meal Strategy
- Nutritional Guidelines for 0 to 5 years
- Six Host borough SRF Sports Framework
- Convergence Framework and Action Plan 2011–15.

The Council considers the provision of high quality, safe and accessible open spaces within the borough as essential to ensuring opportunities for physical activity in order to promote healthy living and preventing illness. Areas of quantity, quality or access deficiency should be reduced and where possible eliminated and new public spaces provided. The council will also support and cultivate the provision of innovative opportunities for sport and recreation for all sections and age groups of the community.¹¹⁰ This includes the provision of free swimming for under 18s, 60 plus residents and disabled residents at all times in the borough's leisure centres.

Waltham Forest Council has planning policies in place which seek to reduce the proliferation of Hot Food Takeaways, particularly near schools as a means of combating their known adverse impact on community health.

¹⁰⁸ Sloan S, *et al.* (2007) Early weaning is related to weight and weight gain in infancy, *Child:care, health and development*, 34,1,59-64.

¹⁰⁹ Wilson AC, *et al.* (1998), Relation of infant diet to childhood health: seven year follow up of cohort of children in Dundee infant feeding study, *BMJ*,316,21-25.

¹¹⁰ Waltham Forest LDF Core Strategy 2011.

In 2012 we saw the pilot of the Healthier Catering commitments in Waltham Forest. The project has been a joint effort between Public Health, the community dietitians and Environmental Health. We invited all restaurants in Leyton and Leytonstone High Roads, with a food hygiene rating over 2 stars to attend training on healthier catering. This training delivered by the community dietitians in Waltham Forest ran 'Catering for Health' sessions to encourage local businesses to make their meals healthier by changing their menus and cooking healthier meals. Five local cafes and restaurants in Leyton and Leytonstone took part and have been recognised for making their meals and cooking practices healthier in the run up to the Olympics.

Adults – obesity

Modelled estimate from Health Survey for England 2006–08 suggest that adult obesity in Waltham Forest is 23.4% which is not significantly different from the England average at 24.2%¹¹¹ and Croydon at 24.3%.

Adults – physical activity

In 2012, 58% of adults in Waltham Forest achieved at least 150 minutes physical activity per week.¹¹² This is not significantly different from the England average at 56% and Croydon at 56.8%.¹¹³

Children – obesity

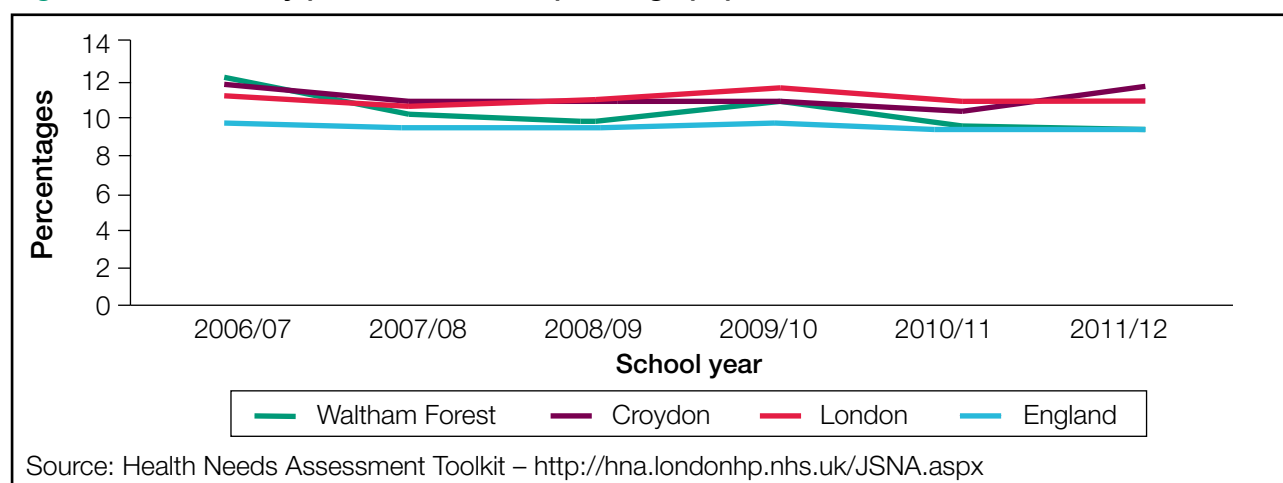
Childhood obesity is measured through the National Childhood Measurement Programme (NCMP). Children in Reception and Year 6 have their height and weight recorded annually.

The recorded obesity rate in children in Waltham Forest in 2011/12 in reception year was 9.%, Croydon 11.8%, London 11% and England 9.5%. For Year 6 the recorded weight of obesity in Waltham Forest 22.9%, significantly more than in England (19%). Close to the London figure (22.4%). In Croydon 22.2% of Year 6 children were obese.^{114, 115}

The recorded overweight rate in children in Waltham Forest in 2011/12 was 12.1% in reception year and 14.7% in Year 6. In the same year for Croydon the recorded overweight rate for children was 12.4% in reception and 15.4% in Year 6.¹¹⁶

Figures 4.16 and 4.17 below show the prevalence of obesity for Reception Year and Year 6 pupils from 2006/07 to 2011/12.

Figure 4.16 Obesity prevalence in reception age pupils



¹¹¹ PHE, Waltham Forest Health Profiles 2013 www.healthprofiles.info

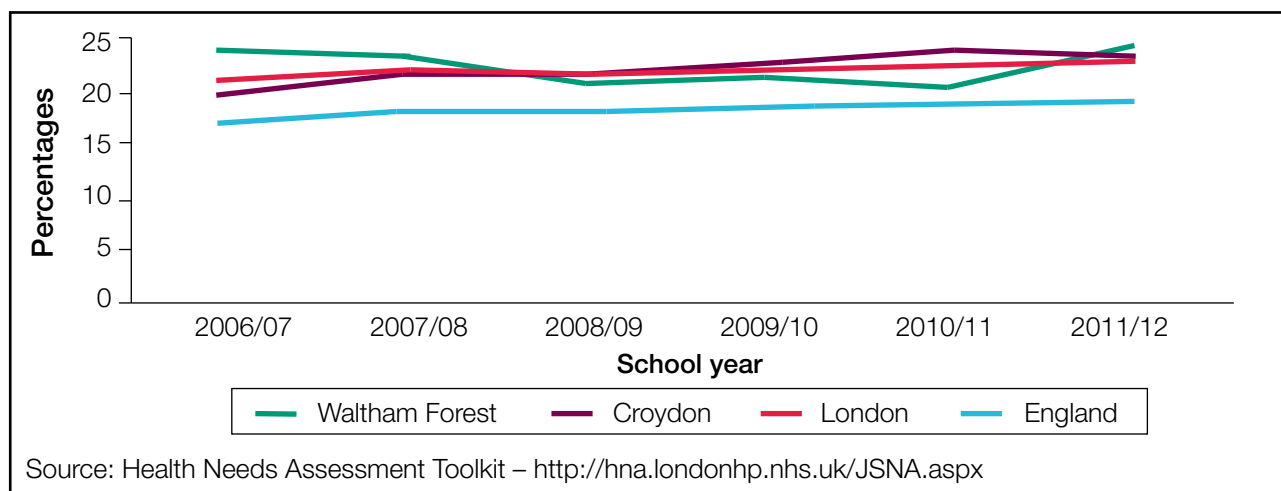
¹¹² PHE, Waltham Forest Health Profiles 2013 www.healthprofiles.info

¹¹³ PHE, Croydon Health Profiles 2013 www.healthprofiles.info

¹¹⁴ Child health profile, www.chimat.org.uk

¹¹⁵ Child health profile, www.chimat.org.uk

¹¹⁶ The Health and Social Care Information Centre, Lifestyle Statistics/Department of Health Obesity Team NCMP Dataset.

Figure 4.17 Obesity prevalence in Year 6 pupils

Children – physical activity

The percentage of children of school age (5 to 18 years) participating in at least three hours of high quality PE and sport per week in 2009/10 was 61.3%, which was significantly better than Croydon (55%) and England (55%).¹¹⁷

There is no longer a public health indicator for measuring physical activity in children. The Department of Health's Start Active, Stay Active (2011) updated the existing guidelines for children, young people and adults and includes new guidelines for early years and older people for the first time in the UK.

What are the effective interventions?

The increase in the number of overweight and obese children and adults has been documented in a number of significant reports and Government White Papers. The White Paper Healthy Lives, Healthy People: A call to action on obesity in England (2011) had ambitions for:

- a sustained downward trend in the level of excess weight in children by 2020
- a downward trend in the levels of excess weight averaged across all adults by 2020
- Start Active, Stay Active issued by the four Chief Medical Officers of England, Scotland, Wales and Northern Ireland draws on the global evidence for the benefits people can achieve by taking regular physical activity throughout their lives
- Changing Behaviours Improving Outcomes: A social marketing strategy for public health
- The policy issues raised have been translated into national delivery plans, National Service Frameworks and toolkits. These documents are designed to help partners to develop and support local action. They include:
 - 'Choosing Health White Paper' and subsequent delivery plans, Delivering Choosing Health: Making Healthier Choices Easier'; Choosing a Better Diet: A Food and Health Action Plan; and 'Choosing Activity: A Physical Activity Action Plan' (2005)
 - National Service Framework for Children, Young People and Maternity Services, Standards 1,2, and 3 (November 2006)

¹¹⁷ Child health profile, www.chimat.org.uk

- Maternity Matters: Choice, Access and Continuity of Care in a Safe Service (April 2007)
- Physical Activity and the Environment (National Institute for Health and Clinical Excellence (NICE), 2008)
- Let's Get Moving – A new physical activity care pathway for the NHS: Commissioning Guidance (September 2009).

Advice and guidance from NICE includes:

- Clinical Guidance Number 43: Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children (November 2006)
- NICE Dietary interventions and physical activity interventions for weight management before, during and after pregnancy (July 2010)
- NICE guidance on promoting and creating built or natural environments that encourage and support physical activity.

What is being done locally to address this issue?

Our long-term vision is to provide an environment that enables all our residents to make healthy food choices, to stay physically active and to maintain a healthy weight across their lives.

Love Mums is a breastfeeding promotion scheme which aims to encourage mothers to initiate breastfeeding and breastfeed for longer. Love Mums has three strands of work:

1. Baby feeding friendly spaces.
2. Love Mums website (<http://lovemums.org.uk/>).
3. Promoting breastfeeding.

We used the opportunity of the 2012 Olympic and Paralympic Games and its legacy to achieve a maximum momentum, including:

- Free swimming for under 18s and over 60s at all times and are working with partners and voluntary sector organisations to sustain activity including seated aerobic classes, healthy walks, recreational jogging and cycling. We have developed sport specific development groups to create a legacy for the future and are working with local organizations and sports clubs to build capacity through training more coaches and providing more equipment to enable increased participation and opportunity
- Primary and secondary schools are opened throughout the summer holidays providing sport and art cultural activities.

We are improving all of our leisure facilities and have completed the refurbishment of Leyton Gym, Walthamstow Leisure Centre and Leyton Leisure Centre. As well as delivering an urban beach and refurbished tennis courts, we have started to install healthy vending in our centres and upskill our fitness instructors Physical Activity Readiness Questionnaire.

Working with local partners including GLL, Leyton Orient Community Sports Programme, Tottenham Hotspur Foundation and London Legacy Development Corporation we are providing new opportunities for residents to take part in physical activities across the borough.

Challenges locally

Achieving change in levels of obesity is clearly a long-term challenge and interventions must be sustainable. These challenges include:

- Partnership commitment and communication given the breath of the strategy
- Given the financial constraints within the CCG and Local Authority keeping it high on the agenda will be a challenge
- NHS reforms
- Funding and staffing constraints
- Sustainability
- Having a robust structure of accountability for the implementation of the strategy.

What are the priorities for improvement over the next five years?

Our long-term vision is to reduce obesity and support residents to achieve a healthy weight. The work we do to prevent obesity in pre-school children is crucial to achieving this since prevention is more effective than management.

The draft strategy document, Healthy Weight – Achieving a Healthy Weight for All in Waltham Forest is a local approach that provides a public health framework to tackle obesity among adults and children in Waltham Forest. Our document will include the following priorities:

- Increase participation in physical activity by creating social, cultural and physical environments that support and encourage active lifestyles
- promote healthy eating by increasing the availability of and access to healthy food choices and reducing the availability of and access to foods that are high in fat, sugar and salt including promoting taking nutritious school meals
- provide consistent, evidence-based information, education and advice on how to maintain a healthy weight
- provide consistent, evidence-based advice, support and treatment for people who are overweight or obese and their families
- create healthy organisations that support and encourage active lifestyles and healthy eating.

4.5 Active travel – cycling and walking

Executive summary

Transport choices affect the health and wellbeing of individuals and populations. Active travel, (cycling and walking) is an effective and realistic way of increasing physical activity. Based on current trends, it has been estimated that nearly 60% of the UK population could be obese by 2050¹¹⁸. Current Department of Health (DH) advice is that adults should accumulate at least 150 minutes (2½ hours) of moderate intensity activity per week¹¹⁹ and that under 16s should achieve a total of at least 60 minutes a day. Recommended levels of activity can be achieved in one session or through shorter bouts of activity of at least 10 minutes each.¹²⁰

This can significantly reduce a person's risk of many of the major diseases associated with physical inactivity and extend their life expectancy¹²¹ – physically active adults have a 20 to 30% reduced risk of premature death¹²². There is also increasing evidence linking physical activity with mental wellbeing¹²³. It is estimated that only 40% of men and 28% of women in England currently achieve this recommended level of physical activity¹²⁴. Moderate activity includes cycling and brisk walking, which offer the opportunity to incorporate exercise into daily routines at no or low cost, so they have a potentially important role in helping to address obesity. As a host borough of the London 2012 Olympic Games and Paralympic Games, Waltham Forest has a unique opportunity to create a lasting legacy of active travel through improved infrastructure and public realm, supportive policies and promotion.

¹¹⁸ Government Office for Science (Foresight). 'Tackling Obesities: Future Choices' (2007) <http://www.bis.gov.uk/assets/bispartners/foresight/docs/obesity/17.pdf> [retrieved on 22 August, 2011] (p 34).

¹¹⁹ or 75 minutes of vigorous intensity activity spread across the week or combinations of both.

¹²⁰ Chief Medical Officers. 'Start active, stay active: a report on physical activity from the four home countries' Chief Medical Officers (July 2011) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128209, Retrieved on 22 August, 2011.

¹²¹ *ibid.*

¹²² Department of Health. At least five a week. Evidence on the impact of physical activity and its relationship to health. A report from the Chief Medical Officer, London DH 2004. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4080994. Retrieved on 22 August, 2011.

¹²³ Royal College of Psychiatrists. 'Physical Activity and Mental Health' (2009). <http://www.rcpsych.ac.uk/mentalhealthinfoforall/treatments/physicalactivity.aspx>. Retrieved 6 August, 2011.

¹²⁴ Department for Health 'Health Survey for England – 2008: Physical activity and fitness' (2009) <http://www.ic.nhs.uk/pubs/hse08physicalactivity>. Retrieved on 19 August, 2011.

As well as increasing physical activity, interventions to increase active travel have other potential health, social, economic and environmental co-benefits including reduced local air pollution, greenhouse gas emissions and noise, increased social interaction, low cost access to local services and employment. Evidence from the UK and elsewhere has demonstrated that coordinated implementation of a number of complementary policies and infrastructural measures are key to increasing cycling and walking. Incentives to travel actively (promotion and high quality infrastructure) are significantly more effective if aligned with disincentives to travel by car (including the reallocation of road space to cycling, walking and public transport)^{125, 126, 127}.

What is active travel?

Active travel is non-motorised transport involving human physical effort. Cycling and walking are the most common forms of active travel (although other modes, such as push scooters and roller-skating also offer opportunities for active travel, particularly among young people). Public transport may appear to be an inactive mode, but using public transport often involves walking or cycling to and from transport stops and interchanges.

DfT research has found that most people consider distances of up to a mile walkable and trips of up to 5 miles (8km) cycleable. As a result, car trips of up to 5 miles can be reasonably targeted for active travel.¹²⁸

While countries with the highest levels of active travel generally have the lowest obesity rates^{129, 130} medical evidence from across the world links time spent in cars as passenger or driver to an increased risk of weight gain, as calorific expenditure is reduced^{131, 132}.

What is the local picture?

In recent decades the distance travelled by car in England has increased,¹³³ while trips by walking have been in long-term decline. Distances travelled by cycling have remained level in recent years.

¹²⁵ Pucher, J., Dill, J., Handy, S.; 'Infrastructure, programs, and policies to increase bicycling: An international review', *Preventive Medicine* 50 (2010) http://policy.rutgers.edu/faculty/pucher/Pucher_Dill_Handy10.pdf [retrieved on 22 August, 2011].

¹²⁶ Jones T, Pooley C, Chisholm A, Horton D, Scheldeman G. 'Understanding walking and cycling: interim findings from a multi-method approach to investigate household decision making in relation to short journeys in urban areas' (2010). http://www.lec.lancs.ac.uk/research/society_and_environment/cycling/WCTR_TJ_July_2010.pdf. Retrieved on 22 August, 2011.

¹²⁷ Department of Health. 'Active Travel Strategy' (2010) <http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf>. Retrieved on 22 August, 2011.

¹²⁸ Department of Health/Department for Transport. 'Active Travel Strategy' (2010). <http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf>. Retrieved on 19 August, 2011.

¹²⁹ Bassett, D., Pucher, J., Buehler, R., Thompson, D., Crouter, S., 'Walking, cycling, and obesity rates in Europe, North America and Australia.' *Journal of Physical Activity and Health*, 5: (2008) 795-814.

¹³⁰ Davis, A., Valsecchi, C., Fergusson, M. 'Unfit for purpose: How car use fuels climate change and obesity,' London: Institute for European Environmental Policy. (2007) <http://www.yale.edu/transportationoptions/choicematters/documents/UnfitforPurposeCarUseObesityandClimateChange.pdf>. Retrieved 19 August, 2011.

¹³¹ Davis, Adrian. 'Essential evidence on a page – No 7: Weight gain and car use'. (2009). Retrieved on 13 June 2011. http://www.bristol.gov.uk/ccm/cms-service/stream/asset/?asset_id=29542007

¹³² Ewing, R, Schmid, T, Killingsworth R, Zlot A, Raudenbush S; 'Relationship Between Urban Sprawl and Physical Activity, Obesity, and Morbidity'; *American Journal of Health Promotion* 18 (September/October 2003). http://www.activelivingresearch.org/alr/files/AJHP_8_Ewing.pdf. Retrieved 19 August, 2011.

¹³³ Department for Transport. 'Reported Road Casualties in Great Britain: Quarterly Provisional Estimates Q1 2011: Statistical Release' (August 2011) <http://assets.dft.gov.uk/statistics/releases/road-accidents-and-safety-quarterly-estimates-q1-2011/road-accidents-and-safety-quarterly-estimates-q1-2011.pdf>. Retrieved 4 August, 2011.

According to the 2011 Census across England, only 2% of trips are currently cycled¹³⁴. In 2009/10, cycle mode share for Inner and Outer London was 2.9% and 1.5% respectively and 2.1% for Londoners overall¹³⁵. By way of comparison, 26% of journeys in the Netherlands are made by bicycle, with 19% in Denmark, and 10% in Germany¹³⁶. In Greater Copenhagen, 36% of commute trips are currently made by bicycle.¹³⁷

At 0.8%, Waltham Forest currently has a low cycle mode share.¹³⁸ TfL analysis for the north London sub-region¹³⁹ shows that only 5% of the total potential in outer London is actually cycled compared to 14% of that for central London.¹⁴⁰ The Mayor of London is seeking to effect a London-wide cycling revolution. Targets include increasing the number of cycling trips to 5% of trips by 2026. Waltham Forest has set its own targets to increase cycling mode share: 2% by 2013, and 6% by 2025. Transport for London has identified Walthamstow Town Centre and the surrounding area as having high cycling potential¹⁴¹.

The number of walking trips has also been in decline in England, although the overall distance walked has changed little, indicating that people are making fewer, but longer, walking journeys.¹⁴² In London, walking is an important mode of travel, with 21% of journeys made on foot.¹⁴³ 32.4% of trips within Waltham Forest are made on foot¹⁴⁴. This is slightly higher than the Outer London average of 29%, but less than the neighbouring Olympic boroughs of Hackney (36.8%) and Newham (37.8%). While there is no London-wide target, TfL seeks to increase London's walk mode share to 24 %, and Waltham Forest council's target is to achieve 34% walk mode share by 2013 and 37% by 2025. These targets reflect current and proposed schemes to improve walking routes, the urban realm, smarter travel and sports initiatives and Olympic legacy schemes that promote active lifestyles.

The Council recognises that making provision for cycling and walking which makes these modes more convenient and pleasant can help to encourage a shift from the private car and so contribute to improving health. Cycle infrastructure is being improved as part of the Council's 2012 'street scene' improvements programme (a public realm programme supported by ODA funding). This includes new segregated cycle (and pedestrian) provision at Ruckholt Bridge and along Whipps Cross Road (to Bush Road) which make the Olympic Park and Stratford city centre more accessible by bicycle and on foot, increasing access to jobs, services, shopping and leisure. Public realm improvements in Leytonstone High Road and Wood Street are enhancing the environment for pedestrians, e.g. through high quality pavements, tree planting and improved lighting.

¹³⁴ Department for Transport. 'Local area walking and Cycling in England 2011/12'. <https://www.gov.uk/government/organisations/department-for-transport/series/walking-and-cycling-statistics>. Retrieved 28 August 2013.

¹³⁵ Transport for London. 'Travel in London 3' (2010) <http://www.tfl.gov.uk/assets/downloads/corporate/travel-in-london-report-3.pdf>. Retrieved 23 August, 2011.

¹³⁶ Department for Transport/Department of Health. Op cit.

¹³⁷ City of Copenhagen. 'Green Urban Mobility' (2011). <http://www.kk.dk/sitecore/content/Subsites/CityOfCopenhagen/SubsiteFrontpage/LivingInCopenhagen/CityAndTraffic.aspx>. Retrieved on 29 August, 2011.

¹³⁸ Waltham Forest Council. Draft Local Implementation Plan (Waltham Forest) (2011).

¹³⁹ Transport for London. Sub regional transport plan: North (2011). <http://boroughs.tfl.gov.uk/documents/general/north-london-sub-regional-transport-plan.pdf>. Retrieved 18 August, 2011.

¹⁴⁰ Transport for London. 'Analysis of Cycling Potential Policy Analysis: Research Report' (Dec 2010) <http://www.tfl.gov.uk/assets/downloads/roadusers/Cycling/analysis-of-cycling-potential.pdf>. Retrieved 30 August, 2011.

¹⁴¹ Transport for London. Sub regional transport plan: North (2011). <http://boroughs.tfl.gov.uk/documents/general/north-london-sub-regional-transport-plan.pdf>. Retrieved 18 August, 2011.

¹⁴² Department for Transport/Department of Health. Active Travel Strategy (2010) <http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf>. Retrieved 22 August, 2011.

¹⁴³ Transport for London. Travel in London 5 (2012), TfL, London.

¹⁴⁴ Transport for London. Travel in London 3.

The Council promotes school and workplace travel planning¹⁴⁵, is installing cycle parking in new urban schemes and requires developers to provide cycle parking facilities in all new developments. In addition, it is prioritising measures to address cyclist and pedestrian accident hotspots (such as Lea Bridge Road and Forest Road), and, from 2012 will be introducing a 20mph default speed limit in all residential roads across the borough.

There are 23 miles of cycle lanes on main roads and 20 miles of quiet cycle routes along residential roads and through green spaces. However, as in other parts of London, accommodating cycling alongside traffic and car parking has compromised the quality of some infrastructure (e.g. most on-road cycle lanes are advisory and blocked by parked cars in the evenings and at weekends). Some cycle lanes are narrow and – at between 1.2–1.5m wide – do not comply with best practice guidelines.¹⁴⁶ However, width increases to 2m (recommended by the Department for Transport and Transport for London) in parts of High Road Leytonstone.

Traffic speeds can discourage cycling and walking among both adults and children. Specific data on speeding is not available for Waltham Forest. However, across Great Britain, 46% of cars exceeded the speed limit on 30 mph roads in 2011. On 40 mph roads, 22% of cars exceed the speed limit.¹⁴⁷

Waltham Forest is in the lowest quartile for child killed and seriously injured (KSIs), and the third quartile for cyclist and pedestrian KSIs respectively.¹⁴⁸ Accidents involving cyclists and pedestrians respectively accounted for 7% and 17% of all accidents in the borough for the baseline years of 2006–08. The Council aims to reduce these by at least 33% by 2020.

Waltham Forest has some excellent off-road walking and cycling routes (eg along the Lee Valley Park). These are being enhanced to encourage sustainable access to the Olympic Park and provide attractive traffic-free routes south to the River Thames and north to Enfield, Hertford and Ware. They are a valuable resource, enabling novice cyclists to try cycling and build confidence, providing opportunities for families to walk and cycle together without fear of traffic, and provide short cuts to workplaces in Enfield's industrial estates.

Interventions and policies to increase active travel and widen travel choices have the potential to directly benefit a significant proportion of the population. (45% of households in Waltham Forest do not own a car).¹⁴⁹ In addition, fewer car journeys and more pedestrians and cyclists can make the roads safer for all users.¹⁵⁰ The current relatively low level of car ownership in Waltham Forest is an opportunity to influence travel habits in favour of walking and cycling, supported by public transport and car clubs.

What are the effective interventions?

A combination of interventions (land use and transport policies, street/road design and infrastructure) which facilitate cycling and walking and actively restrain car use are most effective at increasing active travel. In 2008, the National Institute for Health and Clinical Excellence (NICE) published the first national, evidence-based recommendations on how to improve the physical environment to encourage physical activity.¹⁵¹

¹⁴⁵ A travel plan is a strategy and package of measures to reduce drive alone car use.

¹⁴⁶ Department of Transport. Design Manual for Roads and Bridges Volume 5 Section 2 (Feb 2005) <http://www.dft.gov.uk/ha/standards/dmrb/vol5/section2/ta9105.pdf>. Retrieved 29 August, 2011.

¹⁴⁷ DfT. Vehicle Speeds Statistics: Free Flow Vehicle Speeds in Great Britain 2012. (June 2013). Retrieved 29 August 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209104/free-flow-vehicle-speeds-2012.pdf

¹⁴⁸ TfL. Benchmarking data for London boroughs (Oct 2010). http://boroughs.tfl.gov.uk/documents/borough_information/spending_plans/lip-benchmarking-tool-v1.3.xls. Retrieved 31 August, 2011.

¹⁴⁹ Transport for London. Developing a Sub-regional Transport Plan: Interim report on challenges and opportunities (North London). February 2010. <http://boroughs.tfl.gov.uk/documents/general/north-london-challenges-opportunities-v2.pdf> p26. Retrieved 18 August, 2011.

¹⁵⁰ Department of Health. 'Active Travel Strategy' (2010) <http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf>. Retrieved on 22 August, 2011.

¹⁵¹ On creating built or natural environments that encourage and support physical activity.

It recommends that local authorities:

- Ensure planning applications for new developments prioritise the need for people (including those whose mobility is impaired) to be physically active as a routine part of their daily life
- Ensure pedestrians, cyclists and users of other modes of transport that involve physical activity are given the highest priority when developing or maintaining streets and roads (including reallocating road space to walking and cycling, and reducing road capacity for traffic)
- Plan and provide a comprehensive network of routes for walking, cycling and using other modes of transport involving physical activity
- Ensure public open spaces and public paths can be reached on foot, by bicycle and using other modes of transport involving physical activity.

Guidance for urban planners by the Department for Transport and Chartered Institute of Highways and Transportation stresses the need to design high streets, residential and non-trunk roads as 'social spaces', putting pedestrians and cyclists firmly at the top of the road user hierarchy.^{152, 153}

Jones *et al.*¹⁵⁴ and Pucher *et al.*¹⁵⁵ have undertaken studies of walking and cycling in the UK and abroad, and stress the importance of a mix of incentives to travel actively and measures which render car use less attractive for local trips:

*... Whilst getting in a car is the quickest and easiest option for most people, only those most dedicated to walking and cycling will do so regularly. Thus policies to promote walking and cycling are likely to have limited impact unless they are linked to a broader set of transport policies that actively restrict car use and elevate the convenience and status of walking and cycling within towns and cities.*¹⁵⁶

*... key to the success of cycling policies in the Netherlands, Denmark and Germany is the coordinated implementation of [a] multi-faceted, mutually reinforcing set of policies ... these countries implement far more of the pro-bike measures [and] they greatly reinforce their overall impact with highly restrictive policies that make car use less convenient as well as more expensive. It is precisely that double-barrelled combination of 'carrot' and 'stick' policies that make cycling so irresistible.*¹⁵⁷

¹⁵² Department for Transport. 'Manual for Streets' (2007); <http://www2.dft.gov.uk/pgr/sustainable/manforstreets/pdfmanforstreets.pdf>. Retrieved on 22 August, 2011.

¹⁵³ Chartered Institution of Highways and Transportation (CIHT). 'Manual for Streets 2: Wider application of the principles' (2010) (p 7) CHIT, London.

¹⁵⁴ Jones T, Pooley C, Chisholm A, Horton D, Scheldeman G. 'Understanding walking and cycling: interim findings from a multi-method approach to investigate household decision making in relation to short journeys in urban areas' (2010). http://www.lec.lancs.ac.uk/research/society_and_environment/cycling/WCTR_TJ_July_2010.pdf

¹⁵⁵ Pucher, John and Buehler, Ralph (2008) 'Making Cycling Irresistible: Lessons from The Netherlands, Denmark and Germany', *Transport Reviews*, 28:4, 495 — 528 <http://policy.rutgers.edu/faculty/pucher/irresistible.pdf>

¹⁵⁶ Jones *et al.*, op cit, p72.

¹⁵⁷ Pucher *et al.*, op cit.

A large body of evidence, including recent TfL studies^{158, 159} shows that fear of traffic is the most significant and widespread barrier to cycling and walking, so speed and volume of traffic must be addressed if active travel is to be increased. TfL advises that to maintain cycling by existing frequent cyclists and to encourage infrequent and non-cyclists to take up cycling, 'practical measures to increase safety and improve the provision of facilities will be the most effective'.¹⁶⁰ These findings are echoed in surveys of attitudes to active travel conducted at workplaces in Waltham Forest and as part of a survey of the views of cyclists (and those who would like cycle) within the borough, conducted in summer 2012. Further, TfL identifies ease of use of the car in Outer London as an obstacle to take up of active modes.¹⁶¹

Researchers undertaking an ongoing academic study of four English cities¹⁶² conclude that the biggest steps that could be taken to encourage more people to cycle would be to create more segregated cycle lanes along main roads, reduce traffic speed and limit the availability of parking in urban centres, and introduce strict liability legislation to protect more vulnerable road users.

Jones *et al.*¹⁶³ stress the importance of appropriate physical infrastructure to support for walking and cycling:

... for walking [this] includes removal of barriers and parked vehicles on pavements, better maintenance... For most potential cyclists the key requirement seems to be the reduction of road danger when cycling through a combination of slower motor traffic speed in city centres and the provision of dedicated cycle routes that are segregated from traffic where necessary (e.g. along faster and busier arterial routes)...¹⁶⁴

Smarter travel¹⁶⁵ interventions, such as the UK Sustainable Travel Demonstration Towns, have also been successful. Supported by the Department for Transport, these towns implemented a programme of measures (from 2004 to 2009) to increase the use of sustainable modes and reduce drive alone car use, involving a combination of both 'hard' (infrastructure etc) and 'smarter choices' measures.

¹⁵⁸ Transport for London. 'Analysis of Cycling Potential Policy Analysis: Research Report' (Dec 2010) <http://www.tfl.gov.uk/assets/downloads/roadusers/Cycling/analysis-of-cycling-potential.pdf>. Retrieved 30 August, 2011.

¹⁵⁹ Transport for London. Delivering the benefits of cycling in Outer London (Feb 2010) <http://www.tfl.gov.uk/assets/downloads/businessandpartners/benefits-of-cycling-report.pdf>. Retrieved 31 August, 2011.

¹⁶⁰ Transport for London. 'Analysis of Cycling Potential Policy Analysis: Research Report' (Dec 2010) <http://www.tfl.gov.uk/assets/downloads/roadusers/Cycling/analysis-of-cycling-potential.pdf>. Retrieved 30 August, 2011.

¹⁶¹ Transport for London. Op cit.

¹⁶² Understanding Walking and Cycling: research collaboration between Lancaster University, the University of Leeds and Oxford Brookes University.

¹⁶³ Jones *et al.*, op cit.

¹⁶⁴ Jones *et al.*, op cit. p 22.

¹⁶⁵ Smarter travel interventions seek to provide better information, increase opportunities for people to reduce car use, and make alternatives more attractive. They include:

- workplace, school and personalised travel plans;
- travel awareness campaigns, and public transport information and marketing;
- car clubs and car sharing schemes; and
- teleworking, teleconferencing and home shopping.

Taken together the three towns have achieved the following:¹⁶⁶

- Car driver trips per resident fell by an average of 9%
- Cycle trips per resident increased by 26 to 30%
- Walking trips per resident increased by 10 to 13%.¹⁶⁷

One of the most important overall findings was that on average nearly half of all car trips within the towns could be replaced by cycling, walking and public transport.

DfT and independent evaluation has concluded that the programme was very successful in reducing travel by car, and increasing the use of more sustainable modes. It also suggests that the programme offered excellent value for money. Implied benefit-cost ratio (after including environmental, consumer benefit, and health impacts) is very high, probably of the order of 20 or higher¹⁶⁸.

What is being done locally to support active travel?

Through its land use planning policy and practice, the Council is seeking to increase the walkability and cycleability of the built environment in and around all new developments and to reduce the dominance of the private car. The Council is currently updating development policies and guidance for the period until 2026, and has published its Local Implementation Plan (LIP2) which sets out transport investment priorities until 2014. Both initiatives seek to increase sustainable active travel by prioritising cycling, walking and public transport over private vehicle use.

For example, revised council planning policy promotes new development close to public transport facilities, requires developers to facilitate access by active modes, and has set minimum cycle parking and maximum car parking standards. Where possible, the Council also seeks to retrofit facilities (eg through public realm improvements and targeted grants for workplace cycle parking). In addition, the Council's transport planning team regularly consults with TfL, local residents, businesses and other stakeholders (such as the Waltham Forest Cycling Campaign) to inform decision making on issues affecting pedestrians and cyclists, and to raise public awareness of active travel options, via events such as the Tour de Waltham Forest and Leytonstone Car Free Day.

Waltham Forest Council has long been committed to providing quality cycling infrastructure. The Council has built three large cycle sheds with smartcard access at key rail and underground stations. It is constantly adding to cycle parking facilities across the borough – and will install at least 250 additional stands (500 spaces) by 2015.

The Council funds cycle training in schools (Year 6), free one to one adult cycle training for residents and those who work or study in the borough. It also runs a bicycle recycling centre which sells refurbished bicycles at low cost and hosts cycle maintenance classes. The Council is planning to move the centre to a more accessible location within the borough, and increase the range of activities to create a one stop cycling hub.

¹⁶⁶ Department of Health. 'Active Travel Strategy' (2010). <http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf>. Retrieved on 22 August, 2011.

¹⁶⁷ These results should be seen in the context of a national decline in bus use, cycling and walking during the same period.

¹⁶⁸ Department of Health. 'Active Travel Strategy' (2010). <http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf>. Retrieved on 22 August, 2011] p22.

With Sustrans and TfL, the Council has improved greenways¹⁶⁹ through the borough to the main Olympic Park. Other public realm improvements undertaken in preparation for the Olympic Games are expected to catalyse a significant increase in walking as a main mode of travel in the short term. It is expected that there will be some shift to cycling for slightly longer trips as facilities improve and cycling is normalised across London.

Other Council initiatives supporting active travel include:

- A new 10 point action plan to increase cycling and cycle safety in the borough, adopted by the Council in April 2012
- A commitment to ensure that all of the Council's commercial vehicles (and those of contractors) are fitted with cycle safety devices recommended by TfL (such as Fresnel lenses, visual and audible warning signs). The Council will also be requiring this of developers via Section 106 planning agreements
- Introducing improved crossing points, wider footways and speed tables to improve the environment for pedestrians
- A campaign, run jointly with the Waltham Forest Cycling Campaign, asking driving instructors within the borough to stress cyclists' needs when training new drivers
- Improved signposting for pedestrians and cyclists
- Public events, guided rides and walks (eg Tour de Waltham Forest)
- Improving the permeability of residential roads by allowing contra-flow cycling on one-way streets, wherever feasible
- Plans to enhance cycle parking facilities at stations such as Blackhorse Road and Wood Street
- Work with TfL, Sustrans and other agencies to ensure easy access to the Cycle Superhighways (CSH) in neighbouring boroughs and the London Cycle Network
- Work with TfL and neighbouring boroughs to extend the cycle hire scheme beyond the Olympic Park to Waltham Forest
- Provision of cycle parking, engaging with local businesses and the NHS to run cycling promotion events and implementation of workplace travel plans to increase active and sustainable commuting within the borough
- As the borough's largest employer, the Council is also taking measures to increase cycling and walking among its own workforce, eg through the purchase and promotion of pool bikes, reducing business mileage by car, a programme of healthy walks for staff, and car parking charges for senior staff and councillors.

What evidence is there that we are making a difference?

The Council holds a large cycling event annually (Tour de Waltham Forest), and this has seen a gradual increase in participants in the four years that it has been running, with over 200 in 2011. The Council's Sport team run a successful programme of health walks, and numbers of participants, and requests for walk leader training, have increased significantly in recent years. As the borough's largest employer, the Council has conducted staff surveys in 2007 and 2010 to assess how its employees travel to work, and how active modes might be encouraged. Cycling has increased from 3% to 9% over this three-year period, and walking from 8% to 9%. School and workplace travel plans in Waltham Forest have also shown increases in walking and cycling over time.

¹⁶⁹ A greenway is a publicly accessible linear space linking parks and other areas (eg through an urban area). They are typically vehicle-free.

What is the perspective of the public on support available to them for active travel?

The Council has a Transport Liaison Group, which includes a wide range of local stakeholders, including the Waltham Forest Cycling Campaign (WFCC). The WFCC has regular meetings with the Council's portfolio holder for Transport and the Environment and with council officers. In 2009 WFCC published a project report, *Movers and Shakers*, in which it reported on the results of a survey of local cyclists, assessed conditions for cycling in the borough and made proposals for improvement.¹⁷⁰

Discussions with the public at sustainable transport events, in schools and workplaces in the borough confirm research that, as in the rest of England, that the main barrier to cycling in Waltham Forest is fear of traffic. Cyclists and pedestrians experience higher rates of injury than motorists.¹⁷¹ However, there is increasing evidence of a 'safety in numbers' effect: whereby the risk of injury is reduced as the number of cyclists increases (Jacobsen, 2003^{172, 173}).

While fear of traffic is a key barrier to more cycling, studies show that safety risks are outweighed by the health benefits – by a factor of around twenty to one. One cyclist is killed per 33 million kilometres cycled – but being sedentary presents a far greater risk. Over 50,000 people die in the UK each year as a result of coronary heart disease related to insufficient physical activity, compared to around 100 cyclists killed on the road annually.¹⁷⁴

Nationally, studies have shown that there is broad public support for measures to promote active travel. The vast majority of adults agree that everyone should be encouraged to walk to help their health (97%), help the environment (94%) and to ease congestion (92%)¹⁷⁵, and recent research by Sustrans found that 70% of people support lower speed limits in residential areas to reduce road danger.¹⁷⁶

More needs to be done to demonstrate the economic benefits of walking and cycling to local businesses, which often overestimate the importance of car borne trade and actively oppose measures that improve the local environment for active travel. In fact, DfT research shows that pedestrians and cyclists can spend at least as much in town centres as those travelling by car (and often more as they tend to visit more frequently), so facilitating access by pedestrians and cyclists is likely to encourage local growth^{177, 178}.

¹⁷⁰ WFCC *Movers and Shakers* (2009) http://www.wfcycling.org.uk/documents/movers_shakers_web.pdf. Retrieved 29 August, 2011.

¹⁷¹ National Audit Office: *Improving road safety for pedestrians and cyclists in Great Britain* (2009).

¹⁷² Jacobsen PL. Safety in numbers: more walkers and bicyclists, safer walking and bicycling *Injury Prevention* 2003 9 (3), p. 205 <http://www.ncbi.nlm.nih.gov/pubmed/12966006>. Retrieved 31 August, 2011.

¹⁷³ Robinson DL. Safety in numbers in Australia: more walkers and bicyclists, safer walking and bicycling. *Health Promotion Journal of Australia*. 2005 Apr;16 (1):47-51. <http://www.ncbi.nlm.nih.gov/pubmed/16389930>. Retrieved 31 August, 2011.

¹⁷⁴ Department for Transport/Department of Health. *Active Travel Strategy* (2010). <http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf>. Retrieved 22 August, 2011.

¹⁷⁵ ONS Omnibus Survey, 2002 cited in Department of Health. 'Active Travel Strategy' (2010). <http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf>. Retrieved on 22 August, 2011, p44.

¹⁷⁶ Sustrans (2012). *20mph: A snapshot of the evidence* http://www.sustrans.org.uk/assets/files/Press/0212_Summary_of_arguments%20_for_20mph_updated%200812.pdf. Retrieved on 19 August, 2012.

¹⁷⁷ DfT. 'Local Sustainable Transport Fund: Frequently Asked Questions' <http://assets.dft.gov.uk/publications/adobepdf-165237/Istffaq.pdf>. Retrieved 31 August, 2011.

¹⁷⁸ DfT. *Creating Growth, Cutting Carbon: Making Sustainable Local Transport Happen* (Jan 2011) <http://www2.dft.gov.uk/pgr/regional/sustainabletransport/pdf/whitepaper.pdf>. Retrieved 31 August, 2011.

What more do we need to know?

There is a large and growing body of evidence about what works in promoting active travel. However, further quantitative and qualitative data on barriers to walking and cycling in Waltham Forest is required. The Council is addressing the knowledge gap by:

- asking local residents via a borough wide survey (summer 2012) what would encourage them to try cycling and/or cycle more often
- consulting residents about specific local barriers and perceived safety hotspots in relation to cycling
- cycle counts are being conducted at 23 sites across the borough and will be repeated at regular intervals to enable the Council to monitor its progress towards cycling targets
- similar work, including formal audit of the pedestrian environment, needs to be undertaken with a view to increasing the number of local journeys made on foot.

What are the priorities for improvement over the next five years?

- The Council recognises that it needs to increase its efforts to tackle barriers to cycling and walking in the borough. TfL has summarised key barriers and measures to increase cycling in Outer London¹⁷⁹,¹⁸⁰. Many, but not all, are also relevant to improving the environment for walking. These are listed below and will be key areas for action by the Council over the next five years.

Table 4.7 Transport for London – barriers to cycling in Outer London

Attitudinal barriers for individuals	Physical barriers	Barriers to deliver
Fear of traffic and feelings of vulnerability, particularly when undertaking unfamiliar journeys.	High traffic speeds.	Lack of political support – especially where cycling levels are low – not perceived as a mainstream solution.
Convenience of the car.	Severance, eg major roads and lack of permeability.	Perceived lack of funding.
Individual not sure if cycling is for them.	Lack of cycle parking/cycle facilities at key locations.	Lack of adequately trained and experienced staff within the borough.
Cycling perceived as incompatible with busy, complicated lifestyles.		

¹⁷⁹ Transport for London. Delivering the benefits of cycling in Outer London (Feb 2010). <http://www.tfl.gov.uk/assets/downloads/businessandpartners/benefits-of-cycling-report.pdf>. Retrieved 31 August, 2011.

¹⁸⁰ Transport for London. 'Sub regional transport plan: North' (2011). <http://boroughs.tfl.gov.uk/documents/general/north-london-sub-regional-transport-plan.pdf>. Retrieved 18 August, 2011.

Table 4.8 Solutions to remove barriers to cycling

Attitudinal barriers	Physical barriers	Barriers to local delivery	
Smarter travel	Innovative infrastructure	Partnership working and mainstreaming cycling	Political commitment
Personalised travel planning	Improved permeability	Integrating cycling across all LIP categories	Boroughs leading the way through travel planning
Workplace and school travel planning	Crossing points	Use support available from other organisations	Borough leaders/ members as cycle champions
Led rides	Network of quiet routes	Mainstreaming cycling across borough council and partners	Improved evaluation and monitoring of cycling initiatives
Awareness campaigns, local cycle events	Improved wayfinding	Partnership working with PCTs, workplaces, schools, local cycling groups and police	
Targeted cycle training	Traffic restraint and speed reduction measures		
Changing perceptions of cycling with non-cyclists	Provision of cycle facilities		
	Provision of secure cycle parking		

Source: Delivering the benefits of cycling in Outer London (TfL, Feb 2010).

- In the short to medium term, the Council will seek to protect, improve and enhance its cycle network through the implementation of the Greenways schemes and through improvements to existing routes. It will seek greater co-operation with organisations such as Sustrans and the London Cycle Campaign to identify new routes and improve the cycleability of the wider road network. In addition, the Council will seek to secure high quality cycling and walking infrastructure within, and in the vicinity of, new developments
- As major generators of traffic and its negative impacts, the Council and other large public and private sector employers in the borough are encouraged to develop business travel policies which promote active, green travel and set the standard for other organisations within the borough. These are also cost saving measures. Local authority staff and NHS professionals can act as influential role models for their patients and the wider community. NHS Waltham Forest and Whipps Cross both have workplace travel plans and are promoting active travel to their staff and other stakeholders via participation in the Mayor's Cycling Strategy, Walk to Work events and the London Cycle Challenge. The Council should lead by example in Waltham Forest by developing its own workplace travel plan. In addition, over the next five years, the Council will:
 - Update its cycling strategy and develop a strategy to increase walking
 - Develop sustainable transport supplementary planning guidance for developers, to ensure that opportunities for active travel are built into future development
 - Assess opportunities to create more segregated cycle lanes on busy roads, to increase real and perceived safety for cyclists.

- Increasing awareness of the benefits of active travel to the local economy, in strengthening communities, reducing inequalities and providing access to jobs
- As part of the implementation of the borough's LIP, we will be monitoring progress against targets and indicators relevant to active travel on an ongoing basis. Where targets are not on track, we will analyse causes and evaluate options for improving our performance.

5

**Child and
maternal health**

Executive summary

Maternal & Child Health

Demographics

- Around 26% of the population of Waltham Forest is under the age of 20, an estimated 67,303 children and young people. (Census 2011)
- 62.4% of the 0–19 population is from a black, asian and minority ethnic (BAME) group (Census 2011)
- There has been a 27% increase in births at Whipps Cross from 2006/07 to 2010/11
- From 2010/11 to 2011/12 there has been an 8.2% decrease in the number of births at Whipps Cross.

Waltham Forest is doing well on:

- Breastfeeding initiation – in the top 10% of the country 2011/12¹⁸¹
- Smoking in pregnancy – lower than England but slightly higher than London (2012/13)¹⁸²
- Childhood Immunisations coverage amongst the highest in London¹⁸³
- Emergency hospital admissions for Diabetes lower than London and England (2010/11)
- Lower respiratory tract infections emergency hospital admissions for under 18-year-olds – lower than London (2009/10) and England
- Gastrointestinal emergency admissions for persons under 5-years-old – lower than London and England (2011/12)
- Accident and Emergency attendances for under 5-year-olds – lower than London but higher than England (2010/11)¹⁸⁴
- Elective hospital admissions for 0 to 4-year-olds, 5 to 9-year-olds and 10 to 14-year-olds ranking lower than average in London (2009/10) Children aged 0–15 years Killed or Seriously Injured in road traffic accidents lower than England (2009–2011)¹⁸⁵
- Oral Health – lower percentage decayed, missing or filled teeth (dmft) than London and England (2012)¹⁸⁶
- Looked After Children – rate of children in care is lower than England average (2011/12)¹⁸⁷
- Road traffic casualties for 0 to 15-year-olds lower than London and statistical neighbours (2010–12).

¹⁸¹ CHIMAT – Child Health Profiles – <http://www.chimat.org.uk/resource/view.aspx?QN=PROFILES>

¹⁸² *Ibid.*

¹⁸³ Public Health Outcomes Framework – <http://www.phoutcomes.info/>

¹⁸⁴ Child Health Profiles – <http://www.chimat.org.uk/resource/view.aspx?QN=PROFILES>

¹⁸⁵ *Ibid.*

¹⁸⁶ *Ibid.*

¹⁸⁷ *Ibid.*

Waltham Forest has some challenges around:

- Infant mortality – higher than London and England rate (2009–11)¹⁸⁸
- Still births, perinatal mortality, low birth weight – higher than London and England (2009–11)¹⁸⁹
- Estimated to have the second highest total congenital and genetic disorders/1,000 births in London
- Healthy Start Vitamins uptake for women and babies – lower than London and England (2011/12)
- Large difference in prevalence of Breastfeeding from Initiation (following delivery) to 6–8 weeks of age¹⁹⁰
- Childhood immunisations coverage – below World Health Organisation (WHO) target of 95% (2012/13)
- Human Papilloma Virus (HPV) vaccination programme coverage – lower than London and England (2012/13)¹⁹¹
- Child Well-being index – rank below England average (2009)
- Emergency hospital admissions for Epilepsy under 18-year-olds – lower than England but higher than London (2010/11)
- Emergency hospital admissions for Asthma under 18-year-olds – higher than London and England (2011/12)¹⁹²
- Injury related hospital admissions for under 18-year-olds – higher than London and lower than England (2011/12)¹⁹³
- Self-harm related emergency hospital admissions rates for (under 19 years) higher than London (2011/12)¹⁹⁴
- Inpatient admission rate per 100,000 aged 0–17 years for mental health disorders with more than 3 days duration higher than London and England (2011/12)¹⁹⁵
- Elective hospital admissions rates for 15-19-year-olds ranked 9th highest in London (2009/10)
- Teenage Pregnancy – higher than London and England (2011)¹⁹⁶
- Percentage with special educational needs in schools higher than London and England average
- The number of Looked after children receiving their health assessments as dropped from 92% in 2011/12 to 76% in 2012/13.

Additionally:

- Young Carers – Numbers accessing specialist provisions and known to local authority is lower than estimated numbers of young carers in the borough.

¹⁸⁸ Child Health Profiles – <http://www.chimat.org.uk/resource/view.aspx?QN=PROFILES>

¹⁸⁹ *Ibid.*

¹⁹⁰ *Health Needs Assessment Toolkit* – <http://hna.londonhpa.nhs.uk/JSNA.aspx>

¹⁹¹ *Ibid.*

¹⁹² HSCIC – <https://indicators.ic.nhs.uk/webview/>

¹⁹³ *Ibid.*

¹⁹⁴ *Ibid.*

¹⁹⁵ *Ibid.*

¹⁹⁶ *Ibid.*

Recommendations

- Implement the local Best Start in Life Children and Young People's Strategy in Waltham Forest (including all priority areas from BSiL Strategy).

0–5 years

- Ensure the action plan developed in response to CQC Inspection report (August 2013) covering Maternity Services at Whipps Cross Hospital is implemented and essential standards of care are met
- Improve the Maternity data system in Whipps Cross University Hospital to provide robust data for monitoring and accurate reporting of Key Performance Indicators including Antenatal and Newborn Screening programme KPIs
- Antenatal and Newborn screening – Implement the recommendations from the Quality Assurance (National Screening Committee) visit as well as implementation of action plans from the detailed local audits to improve services
- Consanguinity – Develop a response to the issue of disability and death due to consanguinity and risk for recessive disorders, including
 - a local community genetic counselling service to provide counselling service to the extended families of a baby/child who has been affected by a recessively inherited condition linked to consanguinity as well as those families of childbearing age at risk for recessive disorders
 - an outreach strategy for professionals and local communities to raise awareness on consanguinity and risks associated with recessively inherited conditions
- Create a Consanguinity register to hold information about babies and children who have been affected by congenital conditions related to consanguinity (including family history) to improve monitoring locally
- Vitamin D – Increase the uptake of appropriate vitamins in pregnancy and early childhood
- Childhood immunisations: Improve immunisation cover for all immunisations (led by the local Immunisation Steering Group)
- Health Visiting: Ensure NHS England commissioning plans meet local needs, establish local governance arrangements to oversee improvements in the service and increase in budget in time for handover to Local Authority in April 2015
- Sustain and seek continuous quality improvement of the Family Nurse Partnership programme and prepare for transition of responsibility to the Local Authority in 2015
- Review the Best Start in Life (BSiL) pilot to align maternal and early childhood services and recruit a coordinator to manage and roll out the programme across the borough based on results of evaluation
- Recruit a Community Breastfeeding Coordinator to develop the Unicef Baby Friendly 7-step plan initiative in the community and align commissioning to the breastfeeding commissioning guidance tool including establishing a well resourced breastfeeding peer support service.

5–19 years

- Review NICE guidelines (non clinical/technology appraisals) related to Children and Young people and put processes in place to audit performance against recommendations as well as developing plans for implementation
- Review local data on emergency hospital admissions for asthma to look at coding issues that may be evident in the data and put appropriate actions in place to reduce admissions including education programmes for children and their families who attend accident and emergency for Asthma to reduce re-attendance if appropriate

- Unintentional Injuries:
 - Undertake a self assessment/audit against the NICE public health guidelines to prevent unintentional injury to children and young people under 15 years
- Joint Working: Identify and improve joint working arrangements between health, social care and education, e.g. mainstreaming and extending Best Start in Life Pilot, use of CAF
- Healthy Schools: Encourage participation of schools in Healthy Schools London programme
- School Nursing: Complete the review of the School Nursing Service to inform the commissioning of the service in 2014/15.

Children with additional needs

- Disabled Children:
 - Review data recording systems already used for recording data on children with disabilities and establish a robust central system for recording this data
- Review adequacy of therapy provision such as Physiotherapy and Speech and Language Therapy and Dietetics for Waltham Forest Children and Young People with additional needs
- Child and Adolescent Mental Health Services (CAMHS): Implement the new CAMHS Strategy including:
 - Tier 2 services: Strengthen support to the universal workforce by improved co-ordination between Tier 2 services
 - CYP IAPT: Monitor the progress of implementation of CYP IAPT
 - Fast Track: Review with Children Social Care the service specification for LAC Fast Track service including access to the service for those in out of borough placements.
- Young Carers:
 - Continue to strengthen early identification of, and data collection on young carers working with voluntary sector to increase take-up of carers' assessments and services among hidden carers
 - Develop a whole family approach to supporting young carers based on rigorous assessment of assessment of needs of the individual young carers and needs of the person cared for
 - Develop formal reporting mechanisms for senior managers and the LSCB to receive reports on outcomes for young carers
 - Promote partnership working and coordination across health, social care and education including responding to safeguarding concerns and information sharing
 - Develop stronger arrangements for transition to adult services to ensure that young carers get the right support when they become adults
 - Implement employability pledge and enable young carers aged 16 and over to access education, employment and training opportunities.
- Domestic Violence:
 - Review the effectiveness of commissioned services and decommission ineffective services
 - Commission evidence-based interventions for children and young people affected by domestic violence
 - Improve identification, referrals and data capture

- Improve access to counselling and practical support for victims including children and young people, as well as perpetrators
- Strengthening coordination and information sharing across the partnership to protect children at risk of domestic abuse.

Looked After Children (LAC) Recommendations

1. Develop sufficiency statement and strategy to have the right placements in the right place at the right time and ensure value for money
2. Foster Carers: Increasing the number of in-house foster carers and reduce high cost placements.
3. Accommodation for LAC: Monitor sufficiency of accommodation for LAC
4. Placements: Decrease placements outside the borough
5. Vulnerable groups: Targeting vulnerable groups e.g. those who may have been victims of Child sexual exploitation, missing children, teenage pregnancy, education provisions
6. Work with Ascham Homes to facilitate LAC/Care leavers access to housing
7. Improve the quality of semi-independent-living and work with providers to Enhance young people's preparation for independent living in adulthood

5.1 Maternal and child health

The Marmot review proposed steps to reach a fairer society and reduce the inequalities gap that exists between groups of people.¹⁹⁷ Giving every child the best start in life was given the highest priority. Action to reduce health inequalities must start before birth and be followed through the life of the child to improve adult outcomes. Reducing the risk factors for poor pregnancy outcomes for example can significantly reduce the number of infant deaths, disabilities and potential long term conditions related to prematurity and low birth weight.

Risk factors for poor health outcomes include low birth weight, smoking and alcohol consumption in pregnancy, poor nutrition, infection, gestational diabetes, maternal obesity, late booking for antenatal care, multiple births, low socioeconomic status and teenage pregnancy.

Demographics

Around 26% of the population of Waltham Forest is under the age of 20 (Total population 258,249 – Census 2011). The Census 2011 population household estimates for England and Wales estimate that there are 67,303 children and young people living in Waltham Forest (see Table 5.1). The highest number of children in a particular age group in Waltham Forest is the under 5-year-olds which make up 31% of the total number of children and young people. The second highest age group is the 5–9 years who make up 24% of all children and young people in the borough.¹⁹⁸

Table 5.1 The number of Children and Young people in Waltham Forest (less than 20 years) broken down by age bands and sex

Age groups	Males	Females	Total	Percentage
0–4	10,764	10,075	20,839	31.0
5–9	8,425	8,038	16,463	24.5
10–14	7,504	7,256	14,760	21.9
15–19	7,821	7,420	15,241	22.6

Source: 2011 Census.

The Office of National Statistics (ONS) Census 2011 has been used for the ethnicity data with age breakdown. Table 5.2 below shows the number of children and young people broken down by age and ethnicity. Table 5.2 shows 37.6% of children and young people fall into the White ethnic group followed by Pakistani (13.7%) and Black African group (10.2%). Children and young people from black, asian and minority ethnic (BAME) make up 62.4% of the 0–19 age group.

¹⁹⁷ Fair society, healthy lives. 2010. The Marmot Review. Strategic review of health inequalities in England post 2010.

¹⁹⁸ ONS – 2011 Census – <http://www.ons.gov.uk/ons/index.html>

Table 5.2 Number of children and young people (0–19 years) that live in Waltham Forest broken down by age and ethnicity

Ethnicity	0–4	5–9	10–14	15–19	0–19	Percentage
White	8,081	5,578	5,440	6,227	25,326	37.6
Black Caribbean	960	1,068	1,172	1,423	4,623	6.9
Black African	2,137	1,880	1,516	1,340	6,873	10.2
Black Other	909	862	706	557	3,034	4.5
Asian Indian	630	492	487	520	2,129	3.2
Asian Pakistani	2,594	2,478	2,092	2,062	9,226	13.7
Asian Bangladeshi	427	358	293	293	1,371	2.0
Asian Chinese	201	96	69	92	458	0.7
Asian other	1,014	852	765	769	3,400	5.1
Other ethnic group	3,886	2,799	2,220	1,958	10,863	16.1
All ethnicities	20,839	16,463	14,760	15,241	67,303	100.0

Source: 2011 Census.

Maternal Health

Maternal health refers to the health of women during pregnancy, childbirth and the post partum period. It includes issues such as family planning, birth outcomes, recovery from child birth; newborn care; nutrition and breast feeding. Risk factors for poor maternal health include obesity, alcohol, drug and substance misuse, smoking, homelessness, mental ill health, teenage pregnancy, domestic violence, and sexually transmitted infection. Women with low-income, low level of education, previously ill women and multiparous women are more at risk of developing complications during child birth and after delivery.

Births and Characteristics of Women Giving Birth

Live births have increased progressively in Waltham Forest from 2001–12 from 3,510 in 2001 to 4,832 in 2012.¹⁹⁹ In 2012, 63.5% of babies were born to mothers born outside the UK. This has increased from 62.9% in 2010. In 2012, this was the highest percentage compared to our statistical neighbours of Croydon (51.1%), Greenwich (56.1%) and Enfield (60.1%) as well as London (57.4%) and England (26.7%). Waltham Forest is ranked as 10th highest in England where Newham and Brent were the top 2 areas.²⁰⁰

There were 4,643 births for women who were either registered with a GP in Waltham Forest or living in Waltham Forest and not registered with any GP anywhere in 2011/12 (2012/13 data is currently unavailable). For this section they will be referred to as “women delivering in Waltham Forest”. Of these, 3.2% were not residents of Waltham Forest but were registered with a GP in the area and hence the responsibility of Waltham Forest. Among those who were the responsibility of Waltham Forest, 30.4% were first pregnancies and 27.8% were second pregnancies. The general fertility rate has increased from 64.8 per 1,000 females aged 15–44 in 2001 to 77 per 1,000 live births to women 15–44 years in 2011 and is higher than the England (64.2 per 1,000) and London (66.5 per 1,000) averages.²⁰¹

¹⁹⁹ ONS Live births data – <http://www.ons.gov.uk/ons/search/index.html?pageSize=50&sortBy=none&sortDirection=none&newquery=live+births>

²⁰⁰ ONS Live births data – <http://www.ons.gov.uk/ons/search/index.html?pageSize=50&sortBy=none&sortDirection=none&newquery=live+births>

²⁰¹ Live Births, General Fertility Rates and Total Fertility Rates. Office of National Statistics (ONS). Available at: <http://data.london.gov.uk/datastore/package/births-and-fertility-rates-borough>

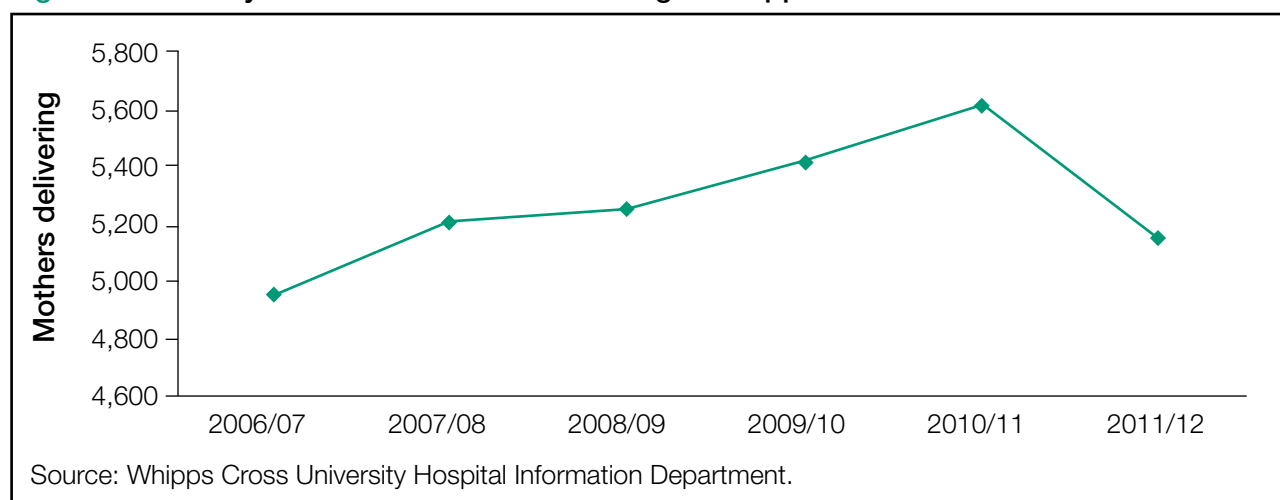
- Women delivering in Waltham Forest in 2011/12 were mostly from deprivation quintile 4 (37.3%) and 5 (59%) (based on Index of Multiple Deprivation by Lower Super Output Area –LSOA). These are the two lowest deprivation groups totalling 96.3% of births. There has been an increase from 87.8% in 2010/11
- Super Output Area), 59% of women delivering in Waltham Forest in 2011/12 were from deprivation quintile 5 (which is ranked amongst the 20% most deprived in England) followed by 37.3% in quintile 4. This is the lowest deprivation group
- 42.9% of women delivering in Waltham Forest during 2011/12 were White (White British, White Irish and Other White ethnicities), followed by Asian women who made up 28.1% of those delivering. This compares very closely with 2010/11. 15.8% of births were to women from the Black ethnic group
- When ethnicity is broken down further (16 ethnic groups), the highest single ethnic group with 23.4% were the White Other ethnic group. This group would include the Eastern European and other White ethnic backgrounds (4.2% had unknown ethnicities)
- The second highest ethnic group was White British (18.8%) followed by Pakistani (16.5%) and Black African (9.6%)
- 60.4% of women delivering were aged 25 to 34-years-old
- Residents of Walthamstow accounted for 48.3% of the deliveries, while Leyton/Leytonstone constituted 32.6% of the deliveries and Chingford 15.9%
- The largest proportion of deliveries in 2011/12 was from Lea Bridge (7.7%), High Street (6.2%), William Morris (6.2%) and Leyton (6.1%) wards (3.2% were non Waltham Forest residents).

Whipps Cross University Hospital Births

Whipps Cross Hospital serves women who live in or are the responsibility of Waltham Forest but also women who come from elsewhere. Figure 5.1 shows the trends in the number of births at Whipps Cross maternity from 2006/07 to 2011/12. These include Waltham Forest women as well as women from other areas.

- There was a 13.5% increase in births from 2006/07 to 2010/11 from 4,955 to 5,624
- From 2010/11 to 2011/12 there was an 8.2% decrease in births at Whipps Cross from 5,624 to 5,161
- There has been a 27% increase in twin births from 2006/07 to 2010/11.

Figure 5.1 Six year trend in mothers delivering in Whipps Cross



Maternal Mortality

Maternal deaths measure the death of a woman during pregnancy or within 42 days of delivery, spontaneous abortion or termination, provided the death is associated with the pregnancy or its treatment.

Maternal mortality for 15 to 44-year-old women delivering in Waltham Forest was lower (0 per 100,000) than for London (0.62 per 100,000) and England (0.41 per 100,000) during 2008–10. This was also lower than the Outer North East London boroughs (Redbridge, Barking and Dagenham, Waltham Forest and Havering) average which was 0.98 per 100,000 deaths. There were no maternal deaths in Waltham Forest from 2006–08.

From August 2010 – August 2012 there was 1 maternal death which was classified an indirect death. Direct deaths are defined as those related to obstetric complications during pregnancy, labour or puerperium (6 weeks) or resulting from any treatment received, whereas indirect deaths are those associated with a disorder the effect of which is exacerbated by pregnancy.

Women's Experiences of Maternity Services

The Care Quality Commission inspection report from June 2013 found evidence that essential standards of care in Maternity services at Whipps Cross were not being met. The hospital is currently implementing an action plan in response to issues identified.²⁰²

In the Health Care Commission survey of women's experiences of maternity services (2007), Whipps Cross attained a "Fair Performing" rating whereas all other North East London sector hospitals were given a rating of "Least Well" performing (Barking Havering and Redbridge, Barts and the Royal London, Newham General Hospital and Homerton Foundation Hospital Trust). Overall Whipps Cross scored below average in the questions relating to whether women were informed, counselled and supported to ensure they have a positive maternity experience (Whipps Cross score 2.63, national average score 3) and questions around whether there were practices in place to help ensure a high quality and effective maternity service (Whipps Cross score 2.88, national average score 3).²⁰³

²⁰² Care Quality Commission report: http://www.cqc.org.uk/sites/default/files/media/reports/R1HY2_Whipps_Cross_University_Hospital_INS1-773393801_Responsive_-_Concerning_Info_08-08-2013.pdf

²⁰³ Health Care Commission Survey of women's experiences 2007. Whipps Cross score available at: http://2009ratings.cqc.org.uk/_db/_documents/RGCScoredAssessment.pdf

5.2 Children 0 – 5 years

Infant Mortality and Perinatal Mortality

Infant mortality describes the death of a baby under the age of 1 year whereas perinatal mortality describes the death of a neonate/infant up to 7 days of life. Infant mortality, along with life expectancy, is used as a marker of health and health inequalities for nations. The risk factors associated with infant mortality include infants being put to sleep on their stomach, smoking during pregnancy, sharing a bed with parents, low birth weight/prematurity, mothers born outside the UK, teenage mothers, babies registered by the mother alone, births amongst those who are in routine and manual jobs.²⁰⁴

- Infant mortality remained higher than London and England from 1991–93 (9 per 1,000 live births) to 2009–11 (5.6 per 1,000 live births), except in 1995–96 when it dipped below the England 3 year average rate²⁰⁵
- Infant mortality in Waltham Forest fell in 2007 – 2009 and was 4.7 per 1,000 live births. The latest infant mortality data shows that it has increased again to 5.6 in 2009–11 and is now higher than England (4.4 per 1,000) and London (4.4 per 1,000). In 2009–11 Waltham Forest ranked 3rd highest in London out of 33 boroughs for infant mortality, increasing from 6th in 2008–10²⁰⁶
- There were a total of 26 deaths in children less than 1 year old in 2011. This has decreased from 31 deaths in 2010²⁰⁷
- Perinatal mortality (still births and deaths of babies under 7 days) in Waltham Forest was 8.3 per 1,000 births for 2009–11. This is higher than London (7.9 per 1,000) and England (7.5 per 1,000), placing Waltham Forest 11th highest out of 31 boroughs²⁰⁸

Still Births

- In 2009–11, Waltham Forest had a still birth rate of 5.7 per 1,000 live births, higher than London (5.5 per 1,000) and England (5.2 per 1,000). Waltham Forest's ranking decreased from 4th highest in 2007–09 to 14th highest in London in 2009–11²⁰⁹
- There were a total of 21 still births in 2011.²¹⁰

²⁰⁴ Implementation plan for reducing health inequalities in infant Mortality: A Good practice Guide. Department of Health, DCSF. 2007.

²⁰⁵ HSCIC – <https://indicators.ic.nhs.uk/webview/>

²⁰⁶ *Ibid.*

²⁰⁷ *Ibid.*

²⁰⁸ *Ibid.*

²⁰⁹ *Ibid.*

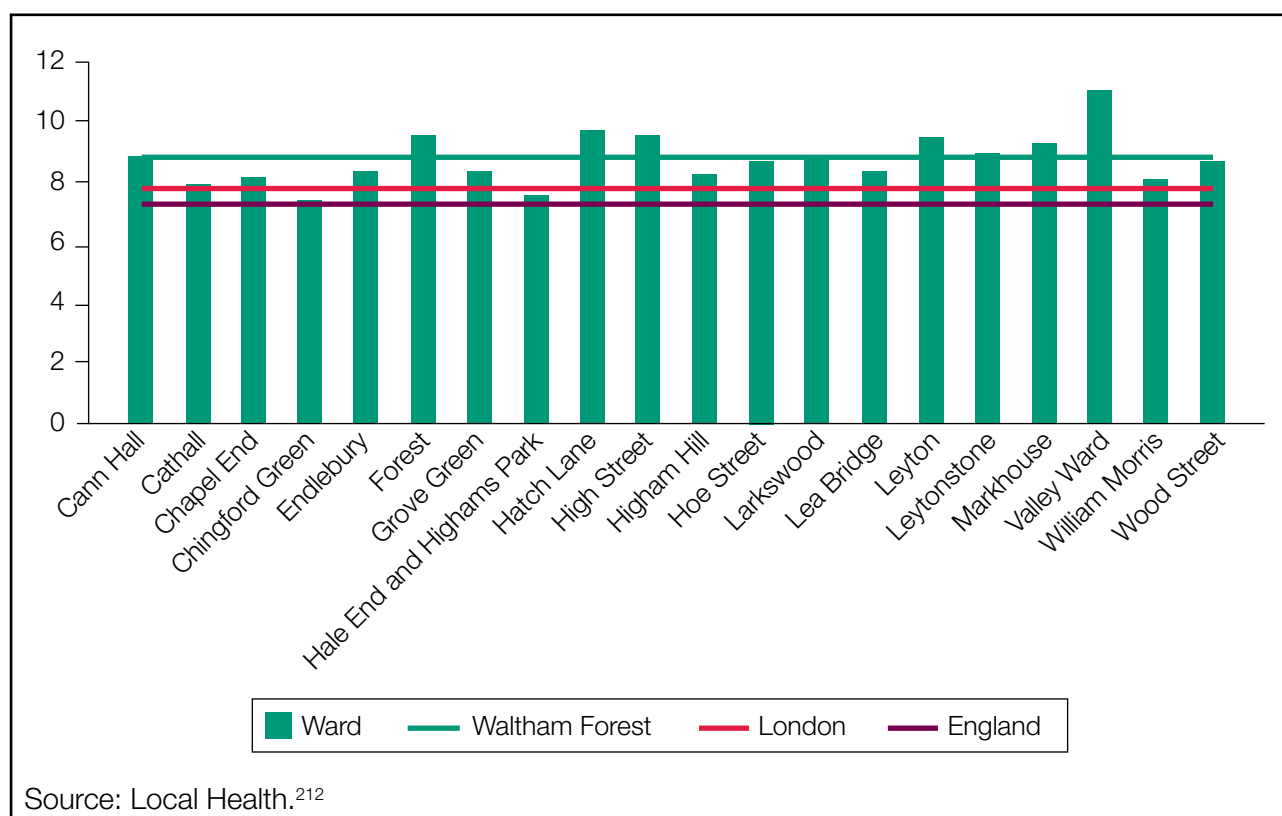
²¹⁰ *Ibid.*

Low Birth Weight and Very Low Birth Weight Babies

Having a low birth weight baby (weighing less than 2,500grams) is strongly associated with deprivation, poor maternal health, lack of antenatal care, belonging to a black and ethnic minority group and smoking during pregnancy. The latest data published from the Office of National Statistics (ONS) show that babies born under 2.5kg were over five times more likely to die suddenly and unexpectedly than those of normal birth weight.

- Waltham Forest had a higher rate of low birth weight babies (8.9%) compared to London (8%) and England (7.4%) in 2011 and was ranked 4th highest in London. (See Figure 5.2). Waltham Forest also had the highest rate of very low birth (less than 1500 grams) weight babies as a percentage of all live and still births in London in 2011²¹¹

Figure 5.2 Percentage of low birth weight babies (less than 2500 grams) by ward 2007–11



Source: Local Health.²¹²

- In 2007–11 the percentage of low birth weight babies was quite similar across the 3 localities: Chingford 9%, Leyton/Leytonstone 9% and Walthamstow 8.8% born with low birth weight. Figure 5.1 shows the percentage of low birth weight babies born by ward as a percentage of all live and still births, while Table 5.3 shows the trend in Waltham Forest compared to London and England from 2005 to 2011
- The ward with the highest percentage of low birth weight babies was Valley ward where 11.2% of babies born between in that area between 2007–11 were born with a low birth weight followed by Hatch Lane ward with 9.9%.

²¹¹ *Ibid.*

²¹² Local Health – Low Birth Weight Births data by Ward 2007-2011 <http://www.localhealth.org.uk/#v=map7;l=en>

Table 5.3 Low Birth Weight babies as a percentage of all live and still births, and all maternal ages, 2005–11

	Percentages						
	2005	2006	2007	2008	2009	2010	2011
Waltham Forest	9.4	9.6	8.3	9.5	8.3	9.4	8.9
London	8.7	8.3	7.9	7.9	7.9	7.8	8
England and Wales	7.9	7.9	7.5	7.5	7.5	7.3	7.4
Waltham Forest ranking out of 33 boroughs London Boroughs	7th	3rd	12th	3rd	10th	3rd	4th

Source: Health and Social Care Information Centre.

Consanguinity

A consanguineous marriage is usually defined as a marriage between people who are second cousins or closer.²¹³ Consanguineous marriages occur in most populations, but in some they are rigorously avoided, whereas in others they are positively preferred. Consanguineous marriage is customary in the Middle East and parts of South Asia, among Irish Travellers, Zoroastrians (religion based on teachings of the prophet Zoroaster), some Jewish communities and many tribes in sub-Saharan Africa and South East Asia. Although the custom is often perceived to be associated with Islam, in fact it is independent of religion. Consanguineous marriages can lead to an increased risk of a recessive genetic disorder/congenital disorder.^{214, 215} This is a disorder where the mother and the father pass on the same defective gene to the baby. This type of inheritance is known as recessive inheritance. In most cases the parents are unaware that they both carry the same disease gene until they have an affected child.

The general risk that a child will have a congenital disorder is around 2%, while the risk for couples who are cousins is approximately doubled, at around 4%. Put the other way round, the general population chance of an unaffected baby is 98%, compared with 96% for couples who are first cousins.²¹⁶ The risk of an affected baby also increased with each generation that has married a close relative.

Waltham Forest has been estimated to have the second highest (6.0 per 1,000) total congenital and genetic disorders per 1,000 births in London. The estimate for the London is 2.5 per 1,000 and England and Wales is 2.0 per 1,000 for the estimated birth prevalence of early-onset congenital and genetic disorders. In the UK 2001 census, minority ethnic groups constituted 7.3% of the population but, when haemoglobin disorders are included, more than 40% of all children with recessive disorders belong to these groups. The uneven distribution of groups at increased risk leads to localized, marked increases in the need for medical genetics and childhood disability services.²¹⁷

Protective Factors for Birth Outcomes

12-Week Booking

In Whipps Cross Hospital, 78.5% of pregnant women booked and attended their first antenatal appointment by 12 weeks gestation, below the target of 88% in 2010/11. This has improved from 72.3% in 2009/10.

²¹³ Bittles, A. H. (1994) The role and significance of consanguinity as a demographic variable. *Popul. Dev. Rev.* 20, pp561–584.

²¹⁴ Jorde LB. (2001) Consanguinity and prereproductive mortality in the Utah Mormon population. *Hum Hered*; 52: pp61–65.

²¹⁵ Sawardekar KP. (2004) Genetic analysis of lethal congenital malformations causing perinatal mortality at Nizwa Hospital, Oman. *Clin Genet*; 66: pp239–43.

²¹⁶ Modell, B. and Darr, A. (2002) Genetic counselling and customary consanguineous marriage. *Nature Reviews Genetics*. 3: pp225–229.

²¹⁷ Morton, R., Sharma, V., Nicholson, J., Broderick, M. & Poyser, J. (2002) Disability in children from different ethnic populations. *Child Care Health Dev.* 28 (1); 87–93.

Stop Smoking in Pregnancy

In 2012/13, 6.3% (283) of mothers were still smokers at delivery. This is slightly higher than 2011/12 where 6% of mothers were still smokers at time of delivery.

In 2012/13, smoking in pregnancy was lower than Greenwich (9.4%), Croydon (7.8%) and England (12.7%) and slightly higher than London (5.8%).²¹⁸

Healthy Start Vitamins

Healthy Start is a UK-wide government scheme to improve the health of low-income pregnant women and families on benefits and tax credits. Women who are at least 10 weeks pregnant and families with children under four years old qualify for Healthy Start if the family is getting Income Support, Income-based Jobseeker's Allowance, Income-related Employment and Support Allowance, or Child Tax Credit. Vouchers can be spent on milk, plain fresh or frozen fruit and vegetables and infant formula milk. Additionally, beneficiaries receive vitamin coupons which can be swapped for Healthy Start Vitamins locally. These vitamins can be bought at a reasonable price for mothers (£0.91 per bottle) and children (£1.80 per bottle) who are not on benefits.

Healthy Start vitamins contain the recommended amount of folic acid and vitamins C and D for pregnant and breastfeeding women and vitamins A, C and D for children aged from six months to four years.

Table 5.4 Healthy Start scheme uptake

Area	Healthy Start Scheme uptake (%)		Women's tablets uptake (%)		Children's drops uptake (%)	
	2010/11	2011/12	2010/11	2011/12	2010/11	2011/12
Waltham Forest	80.1	78.6	0.3	0	0.9	0
Enfield	81.0	79.7	0.0	0	0.0	0
Croydon	75.2	75.4	1.3	1.4	1.4	1.0
London	79.5	78.5	1.1	3.2	1.5	2.9
England	80.1	79.7	2.5	3.6	1.8	2.4

Note.²¹⁹

Based on those eligible and on claims for reimbursement, the uptake of different elements of the Healthy Start scheme (children's drops and women's tablets) in Waltham Forest has reduced from 0.3% (Women) and 0.9% (Children) in 2010/11 to 0 for both elements in 2011/12 (see Table 5.4 above). The 0% uptake in 2011/12 is mirrored in Enfield also but lower than London and England average. Generally the vitamin uptake by children and women is poor across the country but Waltham Forest had a lower uptake compared to London and England for both children's vitamin drop and women's tablets.

Antenatal and Newborn Screening

Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition. The Antenatal and Newborn Screening programme encompasses six specific screening programmes.

²¹⁸ HSCIC – <https://indicators.ic.nhs.uk/webview/>

²¹⁹ Department of Health provide these figures to try to help trusts see changes in their effectiveness from quarter to quarter, and to enable them to broadly compare themselves with others in the region. However, the calculations are based on several estimates and assumptions which should be noted when interpreting data.

These are:

1. Infectious Diseases
2. Fetal Anomaly
3. Linked Antenatal and Newborn Sickle Cell and Thalassaemia
4. Newborn Infant Physical Examination
5. Newborn Bloodspot Screening
6. Newborn Hearing Screening

In the past year there have been some data quality issues with the Antenatal and Newborn Screening Programme due to data systems. Therefore it is not possible to publish the uptake figures for the screening programmes.

0 to 5-year-olds

Breastfeeding

Breastfeeding initiation is recorded at maternity units before babies leave the hospital.

Breastfeeding initiation increased from 79.01% in 2005/06 to 89.1% in 2012/13 ranking Waltham Forest 13th highest in England and in the top 10% of areas in England (Based on 142 out of 151 boroughs that reported data). The percentage Initiating breastfeeding was higher than London (86.8%) and England (73.9%) average. In 2010/11, Waltham Forest was also in the top 25% of the country for breastfeeding initiation.

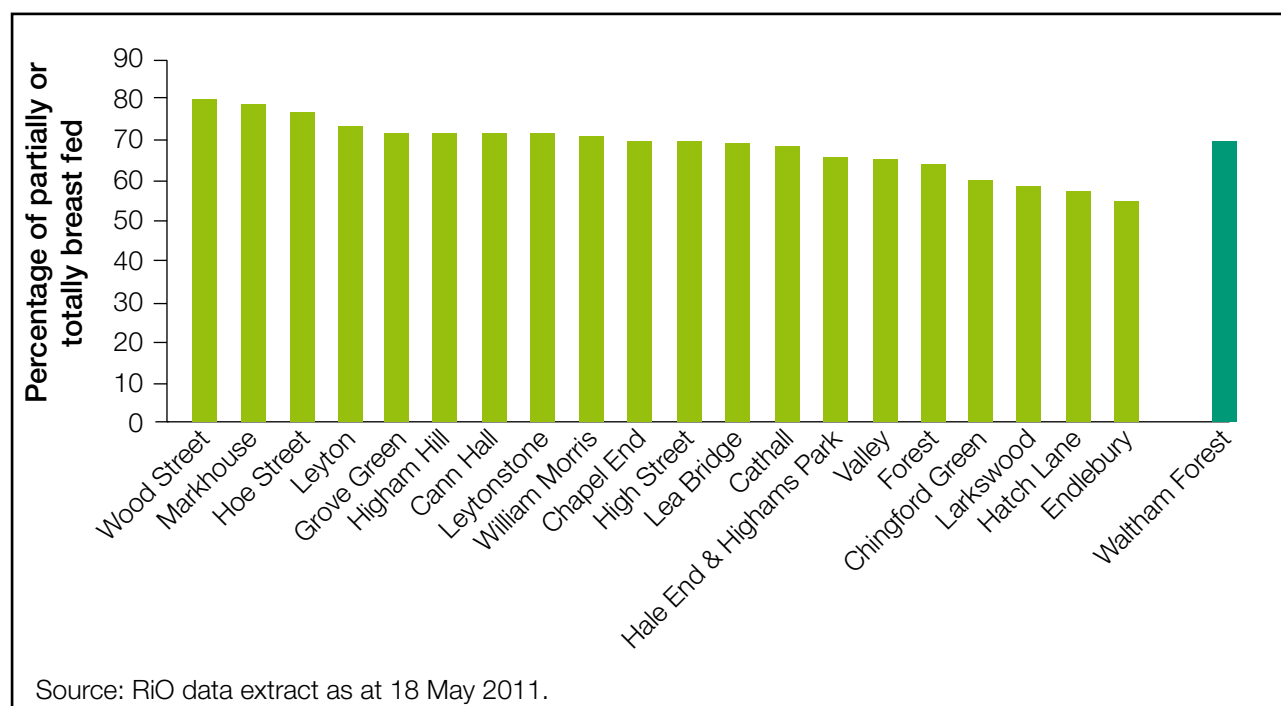
Breastfeeding is also measured at the 6–8 week baby health review where the prevalence of breastfeeding reduces dramatically.

- In 2012/13, 90.6% of those who were due a 6–8 week check had a breastfeeding status recorded (local RiO Child Health Records data as final reporting May 2013). This was lower than in 2011/12 when the figure was 93.1% (local RiO data as at final reporting May 2012) (coverage).
- 63.6% of those due a check in 2012/13 were either partially or totally breastfed (prevalence), down slightly from 2011/12 (65.1%). This is a 25.5% percentage point drop from breastfeeding initiation to breastfeeding at 6–8 weeks.

Analysis by GP practices of babies due a 6–8 week check in 2012/13 (RiO data as at May 2013) showed the prevalence of breastfeeding in those registered with a Chingford GP was lower (53.2%) than those in Walthamstow (65.1%) and Leyton/Leytonstone GP localities (67%).²²⁰

The most recent ward level data available was from 2010/11 where breastfeeding prevalence at 6–8 weeks was reviewed. The wards with the highest prevalence of breastfeeding at 6–8 weeks include Wood Street (78.8%), Markhouse (77.2%) and Hoe Street (75.4%) The wards with the lowest prevalence of breastfeeding include Endelbury (53.7%), Hatch Lane (56.4%), Larkwood (57.4%) and Chingford Green (58.6%) (See Figure 5.3).

²²⁰ RiO data as at May 2013.

Figure 5.3 Prevalence of breastfeeding at 6–8 weeks 2010/11 by ward

Analysis of breastfeeding status at 6–8 weeks in 2010/11 using the 16 ethnic census categories showed the ethnic groups with the highest breastfeeding prevalence were Black African (87.3%), Indian (81.1%), Black Other (78.2%) and Asian Other (76.8%). The ethnic groups with the lowest prevalence of breastfeeding were White and Black African Caribbean (50.7%), White British (57.8%) and Pakistani (64%). The Chinese and White Irish group had very low prevalence (44.4% and 57.1%) but the numbers of babies in these groups were very small.

Based on the 4 broad ethnic groups (White, Black, Asian, Other) the highest prevalence is seen in the Black ethnic group (83.2%) and the lowest is seen in the White ethnic group (62.6%). There was however a large group where the ethnicity of babies was unknown (24.5%); therefore caution should be placed on interpretation of data.

Immunisations

Immunisation protects children against diseases that can kill or cause serious long-term ill health. Inequalities in immunisation uptake persist among poorer families. Table 5.5 shows that performance from 2008/09 through to 2011/12 has either been maintained or improved. However from 2011/12 to 2012/13, coverage has decreased in 5 indicators out of 6. They all however fall below the England average and are below the 95% WHO target.

Table 5.5 Proportion of children who complete immunisation by recommended ages (%)

	Age 1 Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) – (DTaP/ IPV/Hib) – 3 Doses (%)	Age 2 Haemophilus influenza type b (Hib), meningitis C (MenC) – (Hib/MenC) (%)	Aged 2 measles, mumps and rubella (MMR) (%)	Aged 2 Pneumococcal infection (PCV) – (PCV booster) (%)	Age 5 Diphtheria, Tetanus, Polio, Pertussis (DTaP/ IPV) – pre- school booster (%)	Aged 5 measles, mumps and rubella (MMR2) (%)
Waltham Forest 08/09	88	78.7	83.5	75.4	65.7	72.4
Waltham Forest 09/10	90.5	84.8	84.0	81.1	80.9	80.0
Waltham Forest 10/11	91.0	89.4	87.0	85.4	82.1	80.7
Waltham Forest 11/12	92.8	90.0	88.4	87.1	82.7	81.5
Waltham Forest 12/13	89.6	88.2	87.2	86.2	82.6	81.6
London 12/13	91.1	87.3	87.1	86.6	79.9	80.0
England 12/13	94.7	92.7	92.3	92.5	88.9	87.7

Source: RiO Child Health Information system COVER data.

For babies requiring Hepatitis B vaccinations (due to mothers being infected with hepatitis b and to prevent onward infection), in 2012/13, 88.4% (38 out of 43) of babies received their vaccination by 12 months (3 doses of Hep b). This was higher than Enfield (48.3%) but lower than Greenwich (100%). For babies reaching 24 months in 2012/13, Waltham Forest had an uptake of 90.7% (49 out of 54) which was lower than Greenwich (94.2%) and higher than Enfield (29.4%) which is for 4 doses of Hep b vaccine. For 12 months, the hep b coverage has decreased from 2011/12 to 2012/13 when it was 100%. For 24 months coverage remained the same as in 2011/12.²²¹

The BCG (bacillus Calmette-Guérin) vaccine protects against tuberculosis and is offered universally to under 1-year-olds in Waltham Forest. In 2011/12, 3,427 doses of BCG were given to under 1-year-olds in Waltham Forest.²²² The KC50 return which collects this information nationally has been discontinued, therefore there is no 2012/13 data available.

Oral Health

WHO (2003) defined Oral health as the ability to be able to eat, speak, and socialise without active disease, discomfort or embarrassment. Oral health promotion is the activities delivered to ensure that populations are supported in maintaining good oral health. Oral health promotion is also a fundamental aspect of the pursuit of general health and wellbeing.

²²¹ Information Centre – <http://www.hscic.gov.uk/article/2021/Website-Search?productid=12410&q=hep+b+data&sort=Relevance&size=10&page=1&area=both#top>

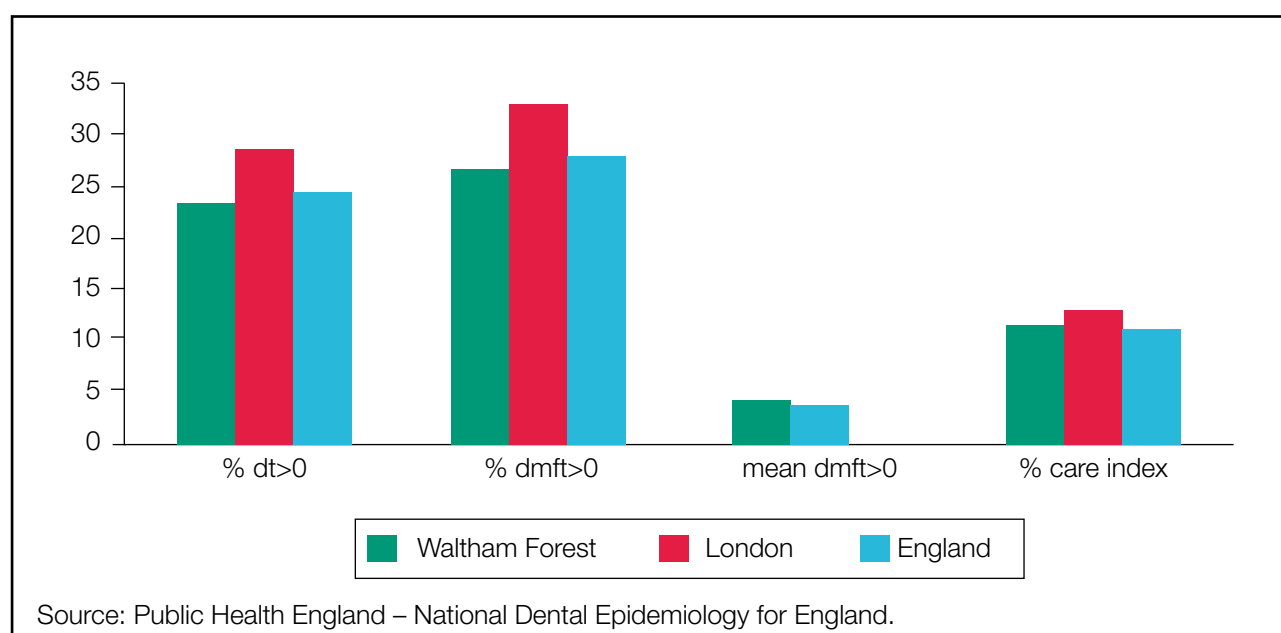
²²² *Ibid.*

The Institute of Dentistry, Queen Mary University of London (QMUL) conducted an oral health survey of 3 to 4-year-olds in Waltham Forest in 2009 in collaboration with Waltham Forest Primary Care Trust (PCT), the study showed that children's oral health is a significant public health problem in Waltham Forest. More than one in five (22.7%) 3 to 4-year-olds had experienced dental decay and most children (95.7%) with decay experience had untreated teeth.²²³

Regionally, Waltham Forest is ranked 15th highest among 29 London boroughs for under 5-year-olds with Decayed Missing or Filled Teeth (1.16 mean dmft). Compared to Enfield (2.05 mean dmft), Enfield had the highest rate compared to all London boroughs.²²⁴

The 2012 national oral health survey examined 212 (51% response rate) children aged 5 years old. Of these in Waltham Forest 26.5% had DMF greater than 0 (i.e. 26.5% of the whole sample had decayed, missing or filled teeth). Of those with decayed, missing or filled teeth, the mean number of teeth that were decayed, missing or filled was 4.36. Decayed teeth made up the highest component at 23.2% of the DMF value and Waltham Forest had a care index of 11.6%, indicating that 5-year-olds are receiving dental care but they are also experiencing dental disease early. Figure 5.4 shows the information from the National 5 year old dental survey in 2012. The DMF has increased from the last survey undertaken in 2008/09 survey where the figure was 3.84. This highlights a need for early interventions that will support the reduction of the early onset of dental disease in our younger population.

Figure 5.4 National 5-year-old dental survey 2012



Family Nurse Partnership (FNP)

The FNP is a preventive programme for young first time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses (Family Nurses), from early pregnancy until the child is two. FNP has three aims: to improve pregnancy outcomes, child health and development and parents' economic self-sufficiency. The programme also supports reducing repeat conceptions to teenage mothers. Waltham Forest is implementing the FNP programme as a wave 3 pilot.

²²³ Marcenes W, Grammati S, Muirhead V, Dahiya M, Lalli A, Fortune F. Oral health in Waltham forest: Children aged three and four years. 2009.

²²⁴ National Dental Epidemiology Programme for England, Oral Health Survey of 5 year old children. 2012. Public Health England.

The recruitment and enrolment data has shown significant improvement with the caseload growing despite having also discharged the second cohort of the programme throughout the 2012/13. The caseload has grown from 35 clients to 59 with 10 discharges over the period, which represents an approximate increase of 42% overall in the year. The attrition (drop out) rate for the programme is also high: 47% for the programme overall against a target of 40%. In terms of child health outcomes, the data outturn for 2012/13 also shows:

- There was an 84% breastfeeding initiation rate for FNP clients, which has increased from 81% in 2011/12
- At 6 weeks 31% of the clients were still breastfeeding which has increased from 25% in 2011/12
- At 6 months 20% of clients were still breastfeeding which has also increased from 12% in 2011/12.

Children's Centres

As of the end of August 2013, there were 15,192 registered children. This has increased by 189 children since 2012.

Central government measures deprivation by dividing England and Wales into 32,482 Super Output Areas (SOAs) and 145 in Waltham Forest. Super Output Areas. In terms of children registered with a Children's Centres, data shows 59% of children (under 5 years) live and come from quintile 5 (the most deprived), 38% from quintile 4, and 3% from quintile 3. There is only 1 SOA in quintile 2 and none in the 1st quintile (least deprived).

From April 2012 to March 2013, of those registered with a Children's Centre, the percentage of those reached are highest from the 5th quintile – 61% of all children reached come from this quintile, showing that the Centre's are working at reaching the children that live in the most deprived SOA's. Waltham Forest does not have any children living in the least deprived quintile looking at the national Super Output Areas of England and Wales, showing that the borough as a whole is in a high deprivation area.

A total of 10,421 Children were reached in 2012/13 and a total of 89,264 contacts were made (counts each time a child visits a centre). 3,514 new children were registered at the Centres during the year. Cathall is the most deprived ward overall with 76% of children reached. The most deprived super output area is based in our Hoe Street ward and 57% of children were reached from this part of the borough.

Children's Centres There are currently 6 Children's Centre clusters, operating across the 17 Children's Centre sites at various locations in the borough. This provides easier access to a variety of advice and support services for parents/carers from pregnancy through to when a child goes to nursery at a primary school. This means there are now only 6 management teams across the borough, and the people in post are responsible for services and provision across their agreed sites (usually 2 or 3 Children Centre locations).

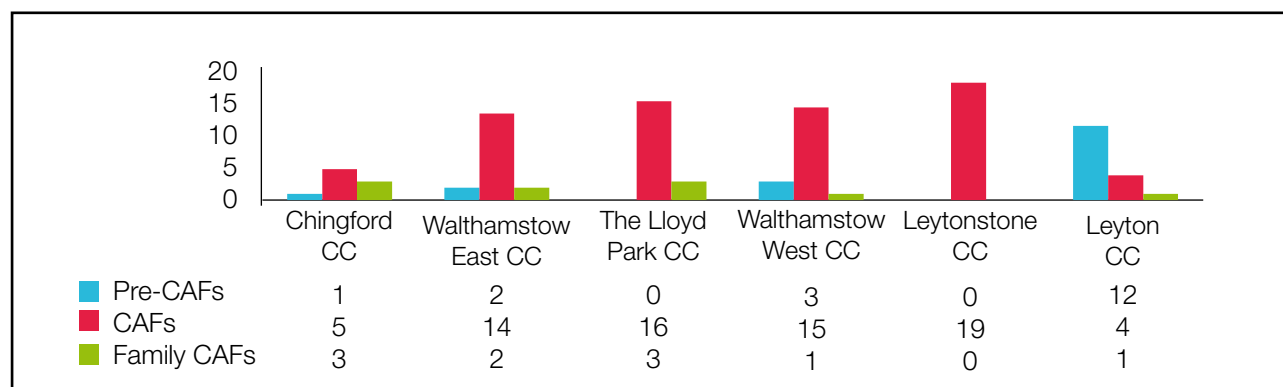
The centres have a particular focus on reaching vulnerable and under- represented groups who may be on low income, teenage parents, ethnic minorities, families with disabled children and single parents, among others. Since April 2013 the Centre's have also been guided by the new Ofsted framework so they have a more extensive list of hard to reach groups they need to target including workless households.

Using ward based analysis Children's Centre's should target wards where the reach is lowest, particularly amongst the most deprived wards. This may involve outreach work to these areas as engagement with Children's Centres is low.

Common Assessment Framework (CAF) data for Children Centres

Figure 5.5 gives the data on CAFs received by Children's Centres Clusters. Leytonstone cluster has received the highest number of CAFs April – November 2013 although Chingford Cluster has received the highest number of Family CAFs.

Figure 5.5 Number of CAFs, Pre-CAFs and Family CAFs received by Children's Centres (April 2013 March 2014)



Please note in the 5–19 years section of this chapter, there are further cross cutting themes (across the 0–19 year age span) discussed including:

- Child and Adolescent Mental Health
- Emergency Hospital Admissions
- Looked After Children
- Special Educational Needs
- Domestic Violence
- Early Intervention and Common Assessment Framework.

5.3 Children and Young People 5 to 19-year-olds

Child Wellbeing

The child wellbeing index in 2009 for Waltham Forest was 324, ranking Waltham Forest 324th out of 354 areas in England (1 is the best and 354 is the worst in England).²²⁵ Within this index, Waltham Forest ranked poorly for material well being, health and disability, education, crime, housing, environment and children in need.

Immunisations

Human Papilloma Virus (HPV)

HPV is one of the most common sexually transmitted infections. It is the main cause of cervical cancer. The aim of the HPV vaccination programme is to reduce the incidence of cervical cancer in women. The HPV vaccination programme provides three doses of HPV vaccine to females before they reach an age when the risk of HPV infection increases and they are put at risk of cervical cancer. The routine HPV programme is given at 3 intervals to 12 to 13-year-olds (Year 8) in school. Waltham Forest reached 75.6% uptake (all 3 doses) for the year 8 cohort in 2011/12 which increased from 74.2% in 2010/11. Waltham Forest was below the London (78.9%) and England (86.8%) average in 2011/12. Waltham Forest was higher than Enfield (69.9%) but lower than Croydon (79.3%) and Greenwich (90.4%).

Diphtheria, Tetanus, Polio school leaver booster (Td/IPV)

Td/IPV is given to young people aged between 13 and 18 as part of the routine childhood immunisation programme. The combined vaccine protects against three different diseases Tetanus, Diphtheria and Polio. In Waltham Forest 2,701 doses were given to school children in 2010/11. (KC50 data collection has been discontinued therefore only 2010/11 data available).

Teenage Pregnancy

Teenage pregnancy rates for 15 to 17-year-old females were higher than that for London and England from 1998 to 2011 (London was only slightly higher than Waltham Forest in 2004). Overall from 1998 to 2010, the rate in Waltham Forest declined from 56 per thousand in 1998 to 31.2 per thousand in 2011.²²⁶ This is the lowest it has ever been in Waltham Forest since the 1998 baseline year. The national target was to reduce teenage pregnancy by 50% by 2010 from the 1998 baseline; Waltham Forest achieved a 18.4% decrease between 1998 to 2010. (Please refer to the Sexual Health chapter of the JSNA for more information on Teenage Pregnancy).²²⁷

Children with Special Needs

An estimate of the number of disabled children nationally is between 3% and 5.4%.²²⁸ Applying this to the 2011 Census population of Waltham Forest suggests that there are between 1,944 and 3,500 children and young people experiencing some form of disability in the borough.

²²⁵ London Health Programmes – HNA Toolkit. <http://hna.londonhpa.nhs.uk/JSNA.aspx>

²²⁶ ONS – <http://www.ons.gov.uk/ons/search/index.html?newquery=Teenage+pregnancy>

²²⁷ Sexual Health Balanced Scorecard – <http://www.apho.org.uk/default.aspx?RID=117779&TYPE=FILES>

²²⁸ Department for Education <http://www.education.gov.uk/researchandstatistics/statistics/allstatistics/a00214996/children-with-sen-analysis-2012>

As at January 2013, of all pupils in school, 23.7% in Waltham Forest have Special Educational Needs (includes those with and without a Statement of Special Educational needs) which is higher than London (19.1%) and England (18.7%).

Overall 1,305 pupils (3% of pupils in all schools) in Waltham Forest had a Statement of Special Educational Needs (SEN) which is similar proportion to London (2.7%) and England (2.8%). This number has decreased from 1,299 in 2012.

Of all pupils in school, 20.6% of pupils have special educational needs with without statements compared to London (16.4%) and England (16%) 11.5% on School Action, 8.8% with School Action Plus and 1.3% with a Statement of Special Educational Needs.

- Of those with a Statement of Special Educational Needs or at School Action Plus in Primary Schools, 37% had Speech, Language and Communication Need, 22.5% had Moderate Learning Difficulties and 18.2% had Behaviour, Emotional and Social Difficulties. For Speech and Language and Communication Needs and Behavioural, Emotional and Social Difficulties (BESD), the percentage was quite similar to London whereas for Moderate Learning Difficulties, the percentage was higher than London and England (See Table 5.6).

Table 5.6 Top 3 needs of Children and Young People with a Statement of SEN or at School Action Plus (Primary Schools)

	Moderate Learning Difficulty (%)	Behaviour, Emotional & Social Difficulties – BESD (%)	Speech, Language and Communications Needs (%)
England	20.3	18.4	30.6
London	14.2	17.8	37.6
Inner London	14.0	17.0	37.6
Outer London	14.3	18.3	37.6
Waltham Forest	22.5	18.2	37.0

- Of those with a statement of Special Educational Needs or at School action Plus in Secondary Schools, 33.7% had Moderate Learning Difficulty, 29.1% had BESD and 13.2% had Speech, Language and Communication Needs. The percentage with moderate learning difficulties in Waltham Forest is much high than London and England average whereas the percentage with BESD was higher than England but slightly lower than London. The percentage with Speech and Language Difficulties was in line with London but much higher than England.

Table 5.7 Top 3 needs of Children and Young People with a Statement of SEN or at School Action Plus (Secondary Schools)

	Moderate Learning Difficulty (%)	Behaviour, Emotional & Social Difficulties- BESD (%)	Speech, Language and Communications Needs (%)
England	21.6	27.7	10.1
London	18.7	30.3	15.4
Inner London	17.9	31.0	18.1
Outer London	19.2	29.8	13.8
Waltham Forest	33.7	29.1	13.2

- Of those with a Statement of Special Educational Needs or at School Action Plus in Special Schools, the top 3 needs were related to Autistic Spectrum Disorder (28.5%), Physical Disability (12.5%) and Visual Impairment (11.8%). For Visual Impairment and physical disability, the percentage is higher than England and London percentages whereas for Autistic Spectrum Disorders, the percentage was in line with London but higher than England (See Table 5.8).

Table 5.8 Top 3 needs of Children and Young People with a Statement of SEN or at School Action Plus (Special Schools)

	Visual Impairment (%)	Physical Disability (%)	Autistic Spectrum Disorder (%)
England	0.8	3.7	21.5
London	1.9	3.6	28.3
Inner London	2.6	0.9	34.5
Outer London	1.6	5.0	24.9
Waltham Forest	11.8	12.5	28.5

Children with Mental Health Needs

The importance of psychological wellbeing in children and young people, for their healthy emotional, social, physical, cognitive and educational development, is well-recognised. Mental health problems in children are also associated with educational failure, family disruption, disability, offending and antisocial behaviour, placing demands on social services, schools and the youth justice system. Untreated mental health problems create distress not only in the children and young people, but also for their families and carers, which can continue into adult life affecting the next generation.

NICE estimate that approximately 20% of women will have some level of mental health need during the perinatal period which would equate to 1,032 women in Waltham Forest.

There are a range of risk factors which have been identified as making children and young people less resilient and more vulnerable to mental ill health.

These include:

- Lone parent families
- Reconstituted families
- Parent with no qualification
- Parents not working
- Receipt of disability benefit
- Household reference person in routine occupational group
- Living in social or privately rented accommodation
- Living in deprived areas with high unemployment, low levels of qualification, and areas with those employed being mainly in unskilled occupations.

Prevalence estimates for mental health disorders in children aged 5 to 16 years have been estimated in a report by Green *et al.* (2004). Using these rates, the table below shows the estimated prevalence of mental health disorder applied to the General Practice (GP) registered patient counts aggregated up to CCG level (2012).

Table 5.9 The estimated number of children and young people with specific mental health disorders

2012	Number
Conduct Disorders	2370
Emotional Disorders	1,510
Hyperkinetic Disorders	630
Less Common Disorders	565

Source: ChiMat website http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=34#ctl00_mainContentPlaceholder_profileReport_34

The 1996 publication 'Treating Children Well' provides an estimate of the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4.²²⁹

Table 5.10 Estimated number of children and young people accessing services at each tier

2012	Number
Tier 1	10,075
Tier 2	4,705
Tier 3	1,245
Tier 4	55

Source: ChiMat website <http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=34#iasProfileSection3>

Table 5.11 shows the number of children accessing Child and Adolescent Mental Health (CAMH) services at each tier from 2008/09 to 2011/12 (Tier 4 is shown using Bed Days and attendances).

The number of children and young people in specialist CAMHS services has also increased from 2008/09 to 2009/10.

Table 5.11 Number of Children accessing specialist CAMHS services at each tier (2008/09 and 2011/12)

		2008/09	2009/10	2010/11	2011/12
Tier 2		135	388	442	141
Tier 3		785	905	1,368	1,267
Total		920	1,293	1,810	1,408
Tier 4	Bed days	874	688	544	1,519
	Appointments attended	No data available	508	399	1,744

Source: Specialist CAMHS database.

²²⁹ Treating Children Well London: Mental Health Foundation, Kurtz Z. (1996).

For children with a higher level of mental health needs, emergency admissions rate for inpatients (0–17 years) with mental health disorders greater than 3 days duration was 11.8 per 100,000 between 2007–10 (3 year aggregated financial years). The rate was higher than London (10.9 per 100,000), Croydon (3.6 per 100,000) and Greenwich (8.5 per 100,000) but lower than England (14.8 per 100,000) and Enfield (15 per 100,000). Out of 29 London boroughs where data was published, Waltham Forest ranked 9th highest.

Table 5.12 Hospital admissions for mental health conditions (inpatient admission rate for mental health disorders per 100,000 population aged between 0–17 years)

Area/Region	Inpatient admission rate per 100,000	
	2010/11	2011/12
Waltham Forest	115.5	146.7
Croydon	86.3	86.5
Greenwich	64.8	57
Enfield	94.4	171.9
London	92.3	87.8
England	93.7	91.3

Source: CHIMAT <http://atlas.chimat.org.uk/IAS/dataviews/view?viewId=320>

Learning Disabilities and Mental Health

Estimation of the population prevalence of learning disability is problematic and should be treated with caution. Estimates are available for age related prevalence as follows; 5 to 9 years (0.97%), 10 to 14 years (2.26%) and 15 to 19 years (2.67%).²³⁰

Table 5.13 shows the estimated number of children with Learning Disabilities and mental health problems which might be expected in Waltham Forest by age.

Table 5.13 Estimated total number of children with a learning disability and Mental Health Problems

	Learning disability	Mental health problem associated with learning disability
Ages 5 to 9 (2012)	220	90
Ages 10 to 14 (2012)	370	150
Ages 15 to 19 (2012)	440	175

Source: ChiMat – <http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=34#iasProfileSection3>

These age-specific numbers reflect the increasing identification of children with mild learning disabilities with age. On the basis of a 40% prevalence of mental health problems associated with learning disability, (the Foundation for People with Learning Disabilities publication²³¹ “Count Us In”).

²³⁰ ChiMat Child Health Profiles 2013 accessed at: <http://www.chimat.org.uk/resource/view.aspx?RID=101746®ION=101634>

²³¹ The report of the committee of inquiry into meeting the mental health needs of young people with learning disabilities. Count Us In. The Foundation for People with Learning Disabilities. Update, Volume 4, Issue 8.

Emergency Hospital Admissions/attendances

Waltham Forest had a lower rate of:

- Emergency hospital attendances in 2010/11 among 0 to 4-year-olds (521.5 per 100,000) was lower compared to London (648.4 per 100,000) but higher compared to England (483.9 per 100,000). It was also lowest among Waltham Forest's statistical neighbours of Croydon, Greenwich and Enfield both in 2009/10 and 2010/11. Waltham Forest ranked 28th highest out of 33 London Boroughs for the 0–4 age group (2010/11)²³²
- Emergency hospital attendances in 2010/11 among 5 to 9-year-olds ranking 9th lowest (in London out of 33 boroughs and 11th lowest in the 10 to 14 year old age group at 272.4 per 100,000 and 323.1 per 100,000 respectively compared to 323.5 per 100,000 and 349.1 per 100,000 for London (although both are higher than the England average which was 255 and 317.1 per 100,000 respectively)²³³
- Diabetes admission rate in persons aged under 19 was 41.3 per 100,000 compared to London (56.9 per 100,000) and England (65.1 per 100,000) in 2010/11. Waltham Forest also had the lowest rate amongst its statistical neighbours of Enfield (45.2), Croydon (54.2) and Greenwich (82.3). The rate in Waltham Forest has also increased from 29.8 per 100,000 in 2009/10 and is now ranked 7th lowest in London²³⁴
- Lower respiratory tract infections admissions for persons aged 15 and under at 204.8 per 100,000 compared to London (205.74 per 100,000) and England (383.12 per 100,000) in 2009/10. Ranking was 12th lowest out of 32 boroughs.²³⁵

Waltham Forest had a higher rate of:

- Emergency hospital attendances for 15 to 17-year-olds at 362.2 per 100,000 compared to London (377.3 per 100,000) but higher than England (332.2 per 100,000). Waltham Forest ranked 14th lowest in London²³⁶
- Epilepsy admissions in persons aged under 18 years (2010/11) was 77.5 per 100,000 which is higher than London (70.4 per 100,000) as well as Croydon (62.4 per 100,000) and Greenwich (70 per 100,000) and lower than Enfield (86.3 per 100,000) and England (80.1 per 100,000). Waltham Forest ranked 9th (same as before no change) highest in London²³⁷
- Gastrointestinal admissions for persons aged under 5 years and in 2011/12 at 523.4 per 100,000 population ranked 14th highest in London. This was lower than London (537.7 per 100,000), England (1131.7 per 100,000), Croydon (595.7 per 100,000)²³⁸ but higher than Enfield (473.4 per 100,000) and Greenwich (521.9 per 100,000). This represents a decrease from 2010/11 when the rate was 660.9 per 100,000²³⁹
- Table 5.11 shows the under 18 emergency hospital admissions for asthma compared with Waltham Forest's statistical neighbours for 2011/12. This shows that the emergency hospital admissions rates for Waltham Forest (367.73/100,000) are higher than London (187.53 per 100,000), England (204.09 per 100,000) and significantly higher than the statistical neighbours (2011/12). Some caution may need to be placed on this data as local information suggests there may be hospital coding issues where children under 5 years old with viral wheeze may be coded as an Asthma Admission

²³² CHIMAT – Child and Maternal Health <http://atlas.chimat.org.uk/IAS/bytheme?themeld=19>

²³³ *Ibid.*

²³⁴ *Ibid.*

²³⁵ *Ibid.*

²³⁶ *Ibid.*

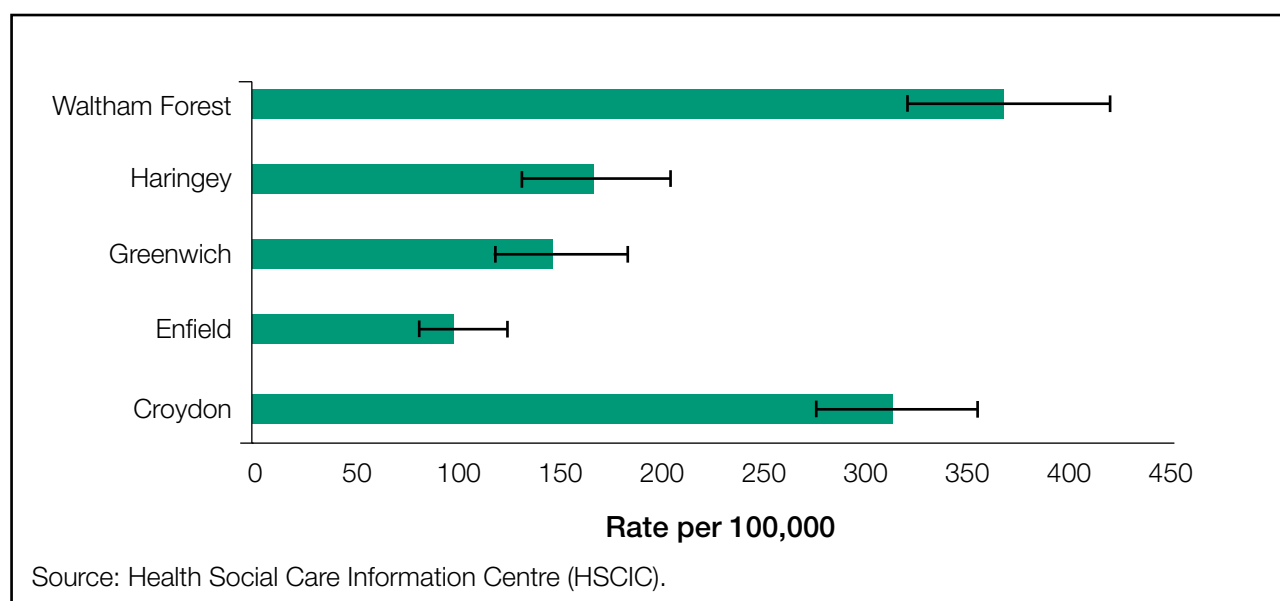
²³⁷ *Ibid.*

²³⁸ *Ibid.*

²³⁹ Compendium of Clinical Health Indicators. Indirect age and sex standardised rate (standardised to 2006/07).

- Number of emergency hospital admissions per patient aged 17 years and under for sickle cell disease (2007–11 aggregated financial years) was 4.1 compared to London (2.8) and England (2.8). This was also higher than Enfield (2.3), Croydon (2.9) and Greenwich (2.2)²⁴⁰
- Waltham Forest's under 18s injury related hospital admissions rate of 117.2 per 10,000 is higher than London (95.1 per 10,000) but lower than England (122.6 per 10,000). Waltham Forest is significantly higher than London²⁴¹
- Hospital admissions for self-harm have increased over recent years. For 2011/12 the rate was 81.5 per 100,000 which was higher than London (76.3 per 100,000). Waltham Forest ranked 5th highest in London for Emergency Hospital Admissions due to self-harm (0–18 years).

Figure 5.6 Asthma Emergency admissions per 100,000 population aged 0–18 years (2011/12)



Management of chronic conditions (asthma, diabetes and epilepsy)

ChiMat (Child and Maternal Observatory) has developed a Disease Management Information toolkit for the conditions Asthma, Diabetes and Epilepsy. Using this tool commissioners and providers can easily compare performance on a number of indicators such as emergency hospital admissions, average length of stay, emergency bed days etc. Using this tool for Asthma Table 5.14 has been produced below. This shows better management of Asthma, if Waltham Forest had the same emergency admission rates per 100,000 0 to 18-year-olds as England, there would be a potential saving to the area of £67,308 and similarly if rates were the same as the top 5% in the country, there is a potential saving of £103,339.

²⁴⁰ CHIMAT – Child and Maternal Health <http://atlas.chimat.org.uk/IAS/bytheme?themeld=19>

²⁴¹ *Ibid.*

Table 5.14 Asthma Disease Management, 2011/12

Tool – Potential cost savings	Waltham Forest PCT	England	Top 25%	Top 5%
Admissions per 100,000 population aged 0–18	355	194	148	108
Cost per admission	£645	£645	£645	£645
Total cost per 100,000 population aged 0–18	£228,886	£125,038	£95,301	£69,446
Potential cost savings per 100,000 population aged 0–18 if rate matches that of England, top 25% or 5% of the country		£133,585	£159,440	£103,848
Potential cost savings – PCT Population aged 0–18 if rate matches that of England, top 25% or 5% of the country		£67,308	£86,582	£103,339

Source: ChiMat data atlas.

There is evidence that educational intervention for children who have attended the accident and emergency department for asthma lowers the risk of the need for future emergency visits and hospital admissions. Local information suggests there may be some coding issues when children present (i.e. those presenting with viral wheeze may be coded as asthma), therefore after review of local data, appropriate interventions can be put in place.

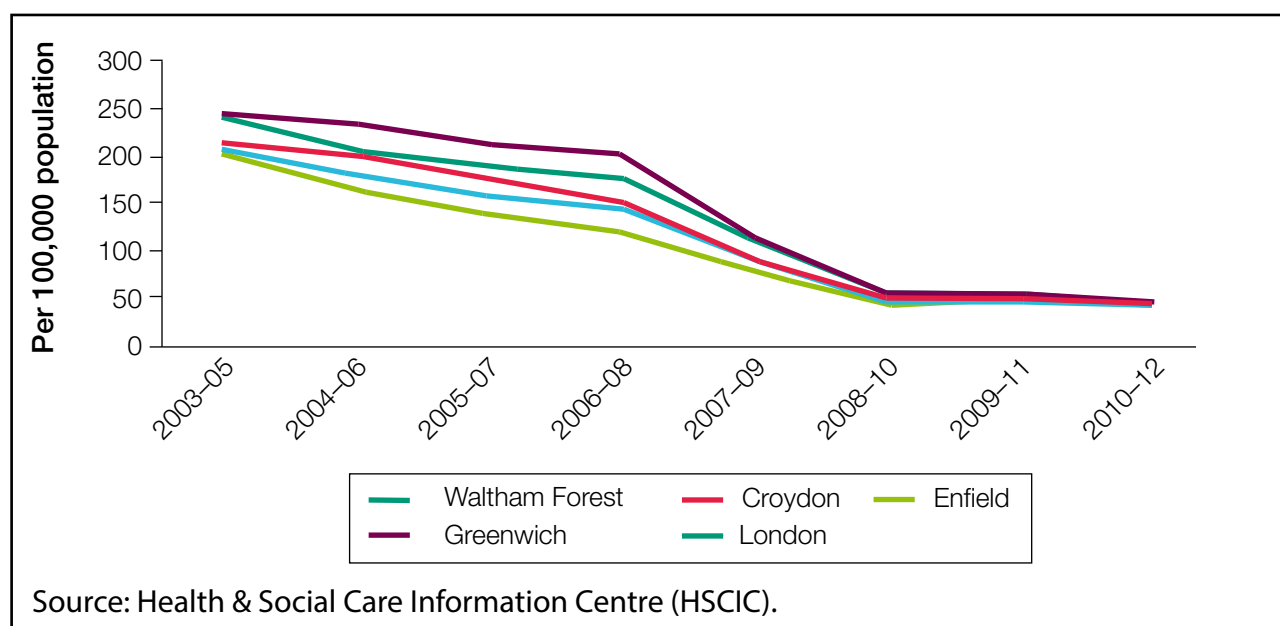
Elective Admissions

Waltham Forest had the 4th lowest admission rate (45.8 per 100,000) for elective procedures among 0 to 4-year-olds, 5th lowest for 5 to 9-year-olds (41.1 per 100,000) and 6th lowest for 10 to 14-year-olds (36.3 per 100,000) out of 31 London Boroughs in 2009/10. However, the rates for 15 to 19-year-olds was ranked 9th highest in London (54.3 per 100,000) and higher than the statistical neighbours of Croydon (42.8 per 100,000), Enfield (53.1 per 100,000) and Greenwich (46.8 per 100,000).

Road Traffic Accidents

Figure 5.7 below shows the trend in Road Traffic Accidents from 2003/05 to 2010–12 for Waltham Forest, London and the statistical neighbours. There is a downward trend in Road Traffic Accidents in general for all the areas in the graph. The figure per 100,000 of the population has been quite similar from 2008–10 to 2010–12 and has been hovering at the around 50 per 100,000 population. The rate in 2010–12 in Waltham Forest is lower than London and the statistical neighbours.

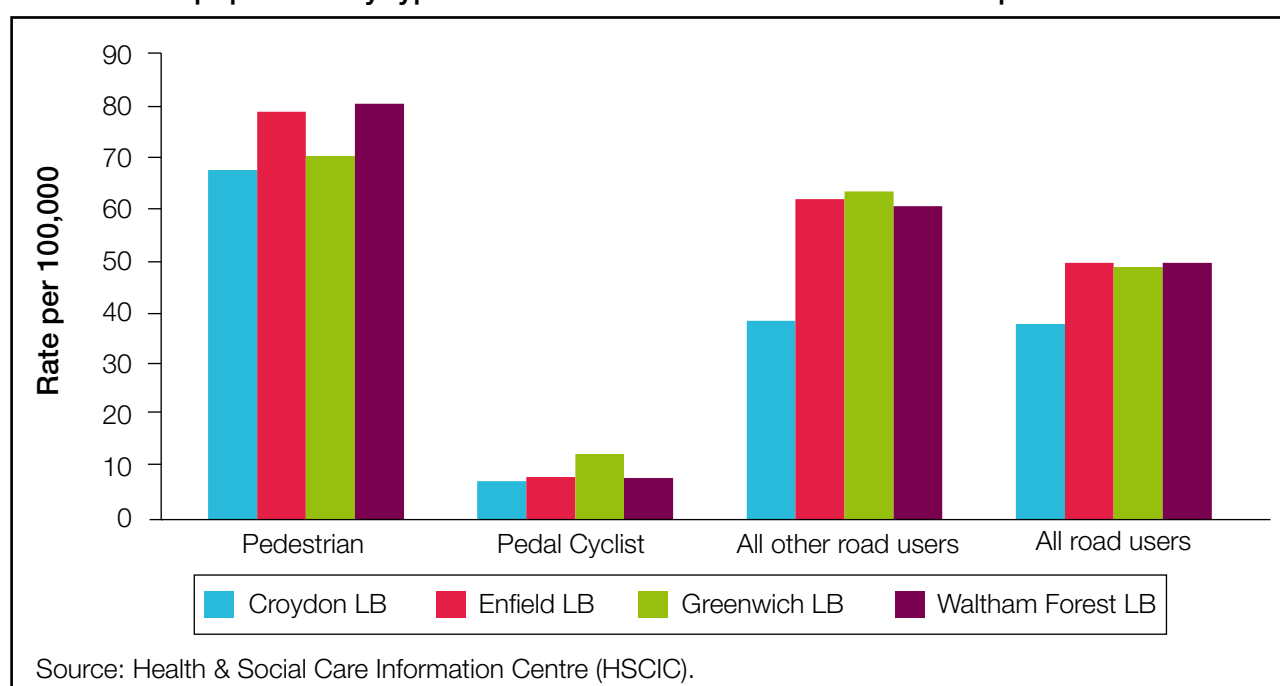
Figure 5.7 Reported Road Traffic Casualties in Children 0–15 years of age per 100,000 population by Local Authority, 2003–12



Using crude rate for children aged 0–15 years who were Killed or Seriously injured in road traffic accidents in 2009–11, Waltham Forest had a rate of 12.3 per 100,000 which is lower than Enfield (16.2 per 100,000), Croydon (16.6 per 100,000), Greenwich (30.2 per 100,000) and England (22.1 per 100,000).²⁴²

Figure 5.8 shows reported road traffic casualties in Children 0–15 years of age per 100,000 by type of user for Waltham Forest and its statistical neighbours 2010–12. For all types of road users, Waltham Forest had lower rates than all its statistical neighbours.

Figure 5.8 Reported Road Traffic Casualties in Children 0–15 years of age per 100,000 population by type of road user in Waltham Forest and comparators 2010–12



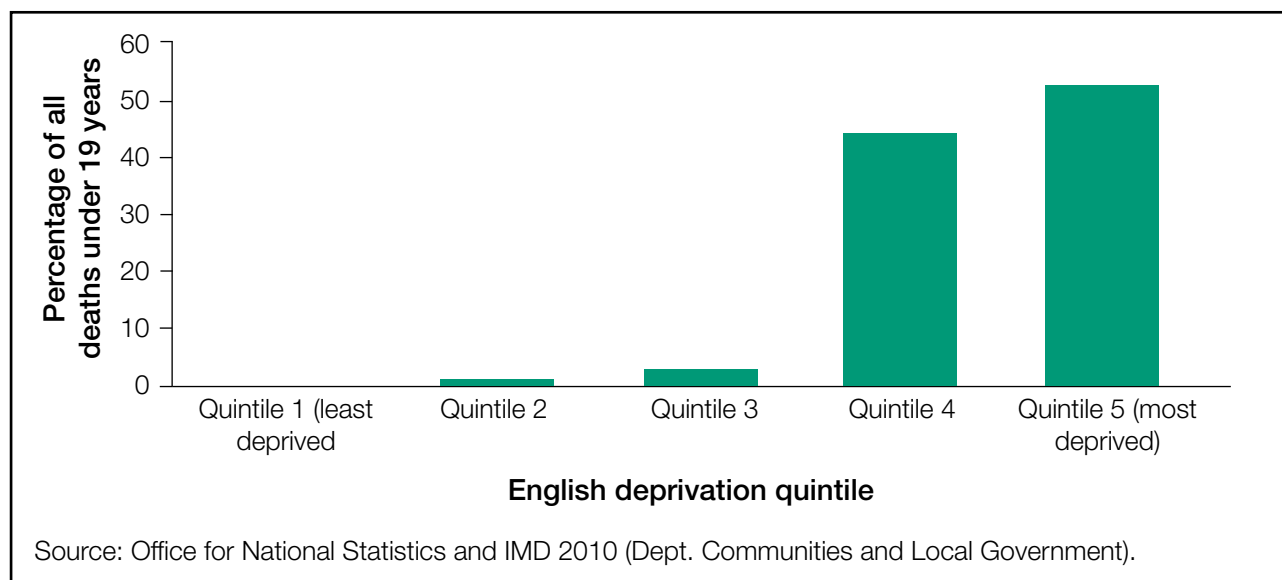
²⁴² ChiMat Child Health Profiles 2013 accessed at: <http://www.chimat.org.uk/resource/view.aspx?RID=101746®ION=101634>

Deaths in children and young people

There were a total of 35 deaths in children and young people under the age of 18 years in Waltham Forest from 2009–11. The majority of these deaths (74%) were infant deaths occurring in the first year of life.²⁴³

Figure 5.9 shows the association between deaths among children and young people and deprivation. Over 95% of all the deaths that occurred in children and young people (2008–10) in Waltham Forest were living in areas that are in the 40% most deprived areas nationally.

Figure 5.9 Deaths in children and young people aged under 19 years, by English deprivation quintile 2008–10



All deaths up to 18 birthday are reported to the Waltham Forest Child Death Overview Panel (CDOP). The panel reviewed a total of 41 unexpected and 92 expected child deaths between April 2009/10 and 31 March 2013. Of the 41 unexpected deaths that the panel have reviewed up to 31 March 2013, 76% were associated with the modifiable factor of co-sleeping. Consanguinity was also a factor in a number of child deaths reviewed by the panel (please see Consanguinity section above for more details).

From the 1 April 2012 until the 31 March 2013, the WF-CDOP received 36 initial notifications of a child death, whom were ordinarily resident of the London Borough of Waltham Forest

In 2012/13 received initial notifications, the top three factors were:

- 39% were due to congenital abnormalities
- 33% perinatal
- 14% consanguinity (please see section above for more details on consanguinity)

Looked After Children's (LAC) Health

The term Looked After Children (LAC) refers to any children or young people who are subject to care orders and those who are voluntarily accommodated by the local authority. This includes placements with other family, friends or foster carers. Looked after children are at an increased risk of poor outcomes e.g. health and employment.

²⁴³ CHIMAT – Child and Maternal Health <http://atlas.chimat.org.uk/IAS/bytheme?themeld=19>

Profile of looked after children in Waltham Forest (as at 31 March 2014)²⁴⁴

There were 262 children in care in Waltham Forest as at 31 March 2014.²⁴⁵ Of these, 56% were male and 44% were female. Waltham Forest's child in care population has reduced over the past few years; from 340 children in 2009/10, to 315 in 2010/11, 310 in 2011/12 and 276 in 2012/13.

At 31 March 2014, the rate of children in care per 10,000 children and young people was 42, which is lower than the England average of 60 per 10,000 and similar areas average of 66 per 10,000 (this refers to 2012/13 data which is the latest published comparable figures).²⁴⁶

The rate per 10,000 children and young people at 31/03/14 has also reduced since 2012/13 where it was 44.

Why children come into care

Neglect is the largest reason for children becoming looked after, closely followed by drug use. Drug use is also a secondary factor in a significant number of domestic violence and physical abuse cases.

Legal Status

Of the 262 children in care on 31 March 2014, 43% were on a Care Order, 33% were accommodated under Section 20, 13% under an Interim Care Order and 10% subject to a Placement Order where adoption is the permanency plan for the child. Freeing Orders and Remands into local authority care were the legal statuses for the remainder of the children (1%).

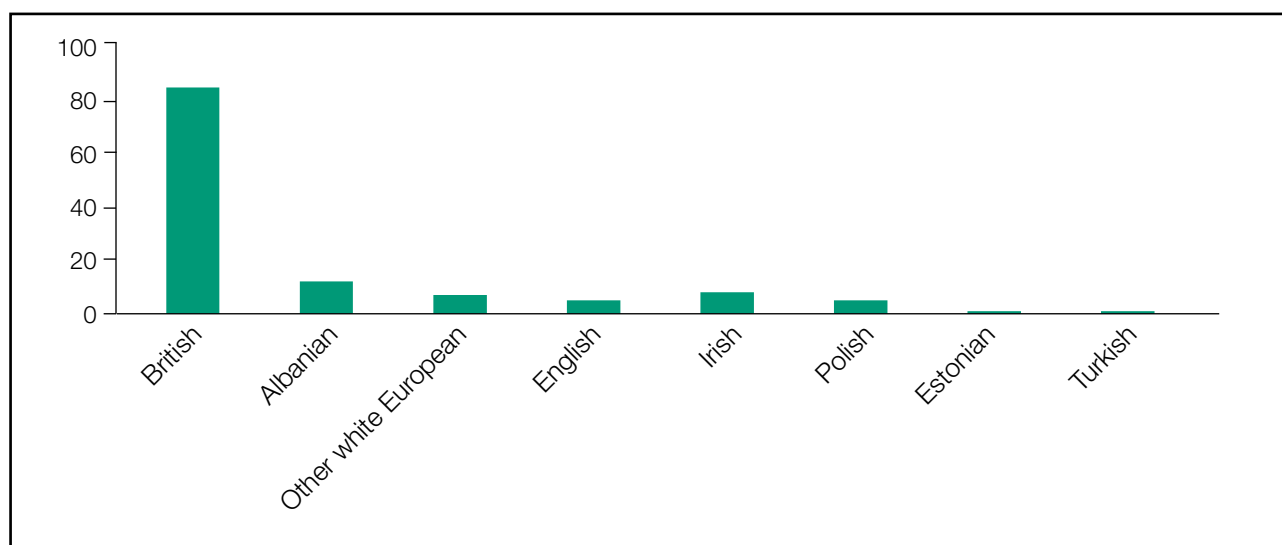
Age

Of the children in care on 31 March 2014: 5% were under a year old; 10% were aged between 1 and 4 years; 14% between 5 and 9 years; 40% between 10 and 15 years; and 31% were aged 16 to 17 years.

Ethnicity

The most sizeable ethnic group of children care is White (47%), followed by Black or Black British (26%) and Mixed Parentage (20%). Asian or Asian British children account for 5% and Other Ethnic Groups 2% of the total LAC population. In addition, Unaccompanied Asylum Seeking Children (UASC) account for 8% of all looked after children. Recent migrants from Eastern Europe mainly feature in the White ethnicity group. The chart below shows a further breakdown of sub-ethnicities within the White category.

Figure 5.10 Additional breakdown of White category



²⁴⁴ London Borough of Waltham Forest, Families Directorate, Local LAC Analysis: 2012/13.

²⁴⁵ Please note that all March 2014 outturns are provisional and subject to data cleansing which will be undertaken as part of the annual statutory returns to the Department for Education. Final outturns will be published in the third quarter of 2014/15.

²⁴⁶ Children looked after in England, including adoption accessed at: <https://www.gov.uk/government/publications/children-looked-after-in-england-including-adoption>

Health

During 2013/14, the percentage of children becoming looked after who received an Initial Health Assessment (IHA) within 28 days of entering care was 59%. This was a reduction from 2012/13 where 69% of children had their IHA within 28 days, but an improvement from 2011/12 where 44% of children had their IHA within the prescribed timescales.

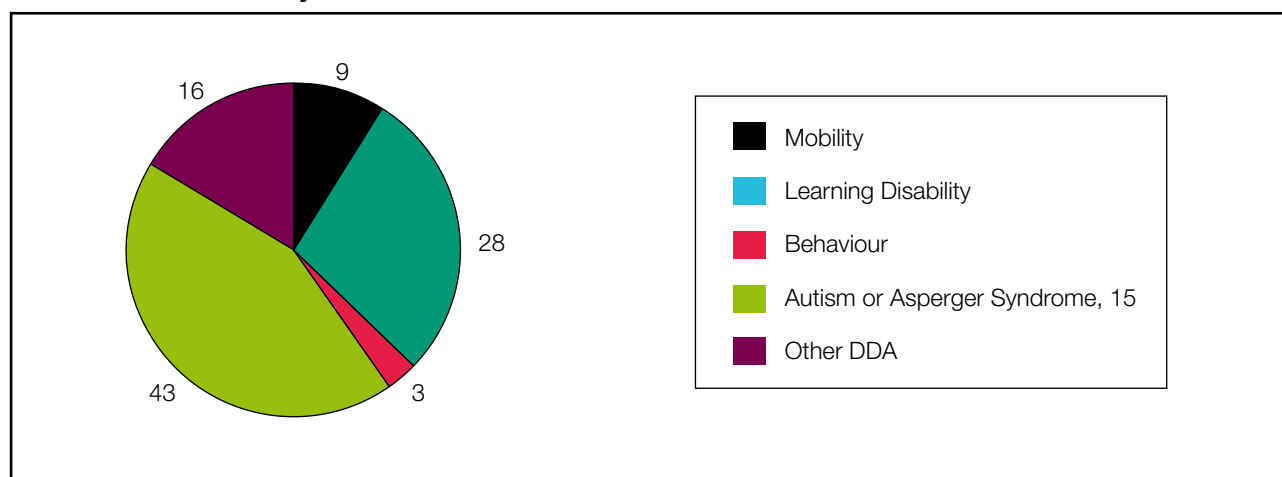
The percentage of children looked after for at least a year that had a Review Health Assessment (RHA) within the last 12 months, as at 31 March, was 86%. This was a slight improvement from the previous year where 85% had their assessment within timescales.

The percentage of children looked after for at least a year that had an up to date dental check as at 31 March 2014 was 90%.

Disabilities

As at 31 March 2014 there were 21 children in care with a recorded disability, which equates to 8% of the total LAC population. The chart below shows each disability; therefore young people who have a multiple disabilities are recorded more than once. Of those children in care with a recorded disability, nine have more than one disability.

Figure 5.11 Breakdown of types of disability, for Looked After Children who have a recorded disability



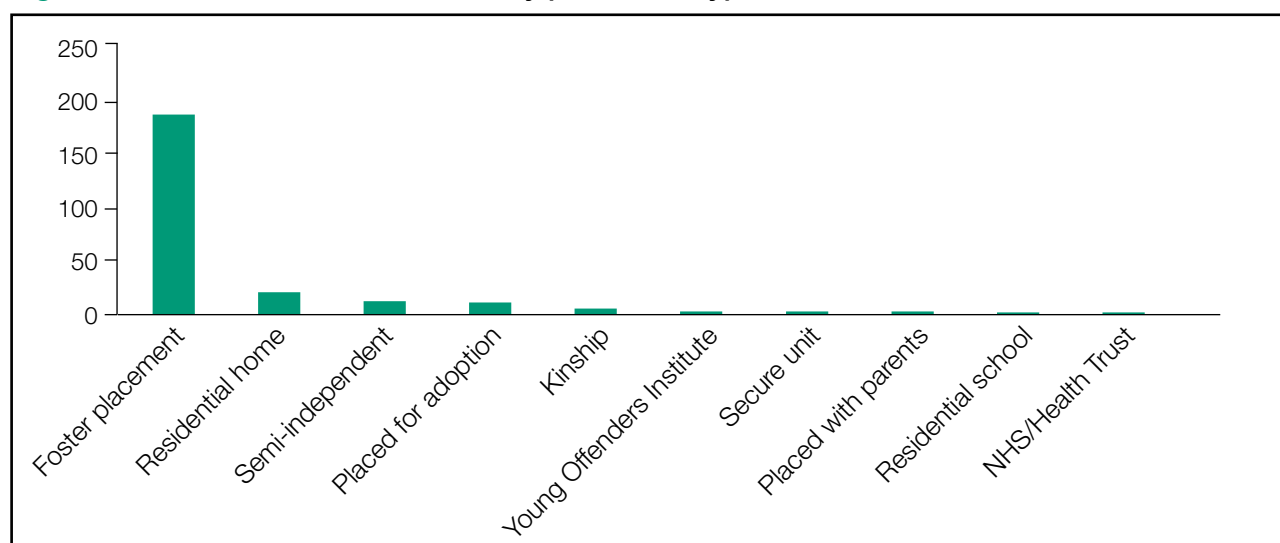
Offending

Of the children in care aged 10 or above who had been looked after for at least year as at 31 March 2014, 4% had offended within the last 12 months. This was a reduction from the previous year, when the percentage of offenders was 6%.

Placement location

On 31 March 2014, 34% of children in care resided within Waltham Forest and 66% were placed outside of the borough. A total of 22% were placed more than 20 miles from their home, which was a slight increase of 2% from the previous year.

Figure 5.12 below shows the number of looked after children and the placement type they resided in, as at 31 March 2014.

Figure 5.12 Looked After Children, by placement type

The most common type of placement for a looked after child as at 31 March 2014 was foster care (75%), followed by residential homes (8%), semi-independent accommodation (5%) and adoptive placements (5%).

Waltham Forest still faces challenges around finding suitable placements for:²⁴⁷

- Children requiring a foster care placement with white foster carers
- Parent and baby placements
- Children requiring a foster care placement with Eastern European carers
- Foster carers able to foster children with disabilities
- Quality local residential home provision for young people with challenging behaviour.

Adoption and Special Guardianship Orders

During 2013/14, 21 children were successfully adopted and 25 children were made subject to a special guardianship order (SGO). The number of adoptions has continued to rise over the last four years and the number of SGOs has more than doubled since 2012/13.

Table 5.15 Number of adoptions and SGOs in Waltham Forest, 2009/10 to 2013/14

Indicator title	2009/10	2010/11	2011/12	2012/13	2013/14
Number of adoptions	16	12	14	19	21
Number of SGOs	13	14	18	11	25
Total	29	26	32	30	46

Source: Families Directorate (Children in Care quarterly dataset), 2009/10 – 2012/13 and Looked After Children and Care Leavers Monthly Performance Dashboard (March 2014).

Table 5.16 shows how quickly Waltham Forest places children in need of adoption with their adoptive families, over each three year rolling period since 2008. The average number of days between a child entering care and moving in with their adoptive family has fluctuated between 2008 and 2014 (which is to be expected due to the relatively small numbers of children involved, making this a volatile measure) but overall, there has been an improvement in performance.

²⁴⁷ WF Sufficiency Strategy 2013 (draft). London Borough of Waltham Forest.

Table 5.16 Average number of days between a child entering care and moving in with their adoptive family in Waltham Forest, 2008–11 to 2011–14 (provisional)

Indicator title	Outturn for 2008–11	Outturn for 2009–12	Outturn for 2010–13	Outturn for 2011–14 (provisional)
Average number of days between a child entering care and moving in with their adoptive family	799	847	693	698

Source: Looked After Children and Care Leavers Monthly Performance Dashboard (March 2014) and Adoption Scorecards 2011, 2012 and 2013.

The average number of days between receiving court authority to place a child for adoption and deciding on an adoptive family has increased overall. During 2013/14 there were some instances of Court delays in issuing a Placement Order until relevant assessments on family members have been undertaken; which has had an impact on performance against this indicator.

Table 5.17 Average number of days between a court authority to place a child for adoption and deciding on an adoptive family in Waltham Forest, 2008–11 to 2011–14 (provisional)

Indicator title	Outturn for 2008–11	Outturn for 2009–12	Outturn for 2010–13	Outturn for 2011–14 (provisional)
Average number of days between court authority to place a child for adoption and deciding on an adoptive family	184	286	273	291

Source: Looked After Children and Care Leavers Monthly Performance Dashboard (March 2014) and Adoption Scorecards 2011, 2012 and 2013.

Domestic violence

Helping the most vulnerable in the community including those affected by domestic violence is one of the Council's priorities. Waltham Forest Council has adopted the Government's definition of domestic violence namely:

“Any incident of threatening behaviour, violence or abuse (psychological, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality”

The definition covers specific issues relating to black, Asian, minority ethnic and refugee communities such as 'honour based violence' (HBV), female genital mutilation and forced marriage (FM) also known as harmful practices. The national Violence Against Women and Girls and The Way Forward Strategies set out a range of measures to prevent, tackle perpetrators and improve access to support as well as strengthen the rights of victims and witnesses.

In view of the sensitivities around domestic violence, there is significant under reporting of domestic violence incidents. At a national level, domestic violence claims the lives of two women each week and thirty men a year.

Nationally, more children than women are affected by domestic violence, even when they may not be the primary victims. At least 750, 000 children a year witness domestic violence.²⁴⁸

There were 572 children referred to social services in 2012/13 whose parents or carers had experienced domestic violence. Table 5.18 represents the number of children referred to social services as a result of parental domestic violence between 2008/09 and 2012/13.

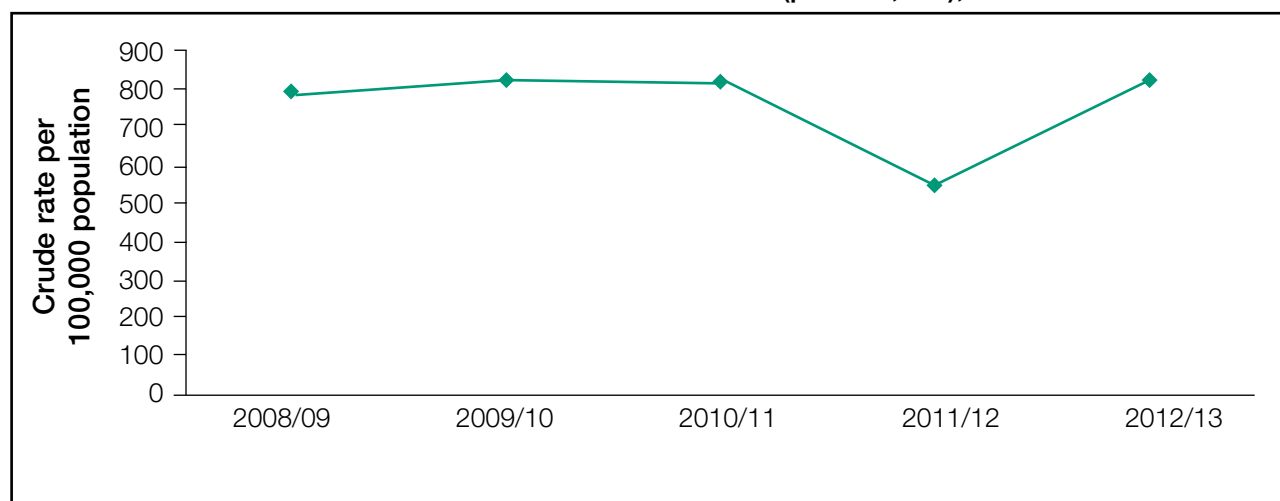
Table 5.18 Referral to Social Services of children whose parents/carers have experienced domestic violence

Year	No. of referrals
2008/09	468
2009/10	493
2010/11	500
2011/12	376
2012/13	572

Source: Framework I- presenting issues.

Figure 5.13 shows that there were steady referrals between 2008/09 and 2010/11. The rate declined in 2011/12 but went up to the 2008/09 and 2010/11 levels in 2012/13.

Figure 5.13 Rate of children (0–19 years) with parents/carers who have experienced domestic violence referred into social services in WF (per 100,000), Trend 2008/09 – 2012/13



Common Assessment Framework (CAF) and Early Intervention

Early Intervention and Prevention service was introduced to the borough in July 2011 and it provides a more holistic package support to agencies around the whole CAF framework.

²⁴⁸ Department of Health (2002) Women's Mental Health – Into the Mainstream Strategic Development of Mental Health Care for Women.

What is the CAF?

The Common Assessment Framework is an assessment tool that can be used by all practitioners working with children and young people from pre-birth to the age of 19.

It has been designed to gather information about their strengths as well as needs. The CAF aims to build single shared picture of what is working well in a child/young person's life and where some support might be helpful.

The CAF both encourages and enables practitioners to work together more effectively in a more integrated way. CAF is a common process, supported by a common form to record information. This includes discussion with the child/young person and their family as well as information and observation from relevant practitioners and services. This single shared picture is then used to plan a way forward. This improves communication, encourages the development of common language and supports information sharing.

What is the Family CAF?

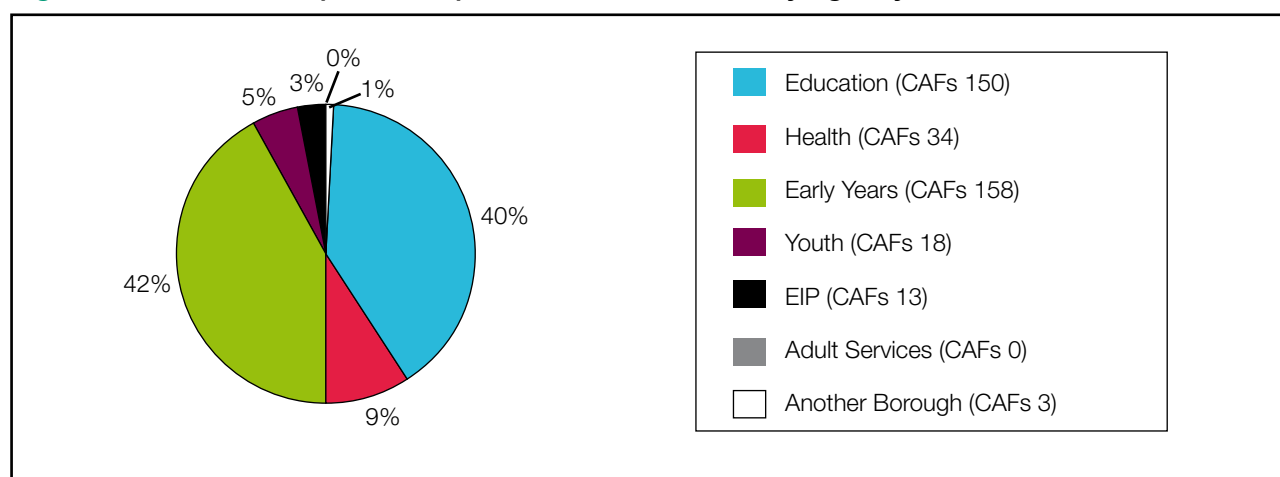
The family CAF provides the opportunity for the family to prioritise their needs (identifying both short term and longer term needs) as well as strengths and identified goals. Family CAFs provides personalized support for individual family members by exploring how the behaviour of other family members impacts on individuals within the family. The intensity and integrated nature of the support provided through the family CAF, means that other agencies will be better informed about family's needs. The family CAF also helps share responsibility for improving family outcomes across a range of services, so that each service does not feel that they are responsible for resolving all the family's issues.

The pilot of the family CAF was introduced in September 2012 and it was decided to pilot the assessment for 3 months. The family CAF has now been adopted for full use in Waltham Forest as practitioners who have used it have found it helpful.

Summary of CAFs received April 2012 – March 2013

Overall, the last CAF compliance report (July 2013) indicates that there has been a 16.6% decrease in CAFs recorded in 2012/13 over 2011/12. In 2012/13 there were 376 CAFs completed whereas in 2011/12 there were 451 CAFs completed. This decrease is influenced by the introduction on the Family CAF (practitioners were given the option to complete a family CAF rather than an individual CAF) as well as the introduction of the financial criteria for the 2 year old FEEs (this meant that less CAFs were being completed for the childcare panel as the children who qualified under the financial criteria, did not need a CAF for panel).

Figure 5.14 below shows the number of CAFs and the agencies who have completed them. Early Years has completed the most CAFs; this was predictable, as CAF is the threshold for 2 year old childcare panel and in order for child to have been considered at panel, child needs a completed CAF (or initial/core assessment if known to social care).

Figure 5.14 CAF completions April 2012 – March 2013 by agency**Family CAF data:**

Between September and December 2012, 14 Family CAFs have been received: 8 of these family CAFs are completed on families with one child, 3 family CAFs are on families with 2 children, 2 family CAFs are on families with 3 children and 2 family CAFs are on families with 4 children (see Table 5.19) In this case, these 14 family CAFs would equal to 28 individual CAFs.

Table 5.19 Family CAFs completed by agency

Agency	Number of family CAFs
Ainslie Wood Primary School	7
Buxton All – Through Primary Phase	1
Church Hill Children’s Centre	1
Edinburgh Primary School	1
EiP	2
Sybourn Children’s Centre	1
Whitehall Primary School	1
Total	14

Capturing the Child's Voice

The Child's Voice is a phrase used to describe the real involvement of children and young people. It means more than seeking their views, which could just mean the child saying what they want, rather than being really involved in what happens. Children's views, wishes and feelings should be the starting point of the process and should be considered alongside parents, carers and professionals' views in order to understand their views (priorities, experiences, wishes, feelings and needs) as part of the decision making.

The Early Intervention and prevention (EIP) has created 3 tools to capture children/young people's voices (age groups 6–7 years, 8–11 years and 12+) to be used by practitioners when working with a child/young person when completing a CAF. The EIP is currently working on creating a tool in capturing the child's voice for the under 5s.

Healthy Schools

Healthy Schools was a joint Department of Health (DH) and Department for Children, Schools and Families (DCSF) initiative that promotes the link between good health, behaviour and achievement. National funding for this was stood down at the end of March 2012. Subsequently, a Healthy Schools London Programme was launched in April 2013 and London Borough of Waltham Forest is committed to supporting schools to achieve the new Bronze, Silver and Gold awards. The 4 core areas include Healthy Eating, Physical Activity, PSHEE, Emotional Health and Wellbeing.

Management of chronic conditions (asthma, diabetes and epilepsy)

ChiMat (Child and Maternal Observatory) has developed a Disease Management Information toolkit for the conditions Asthma, Diabetes and Epilepsy. Using this tool commissioners and providers can easily compare performance on a number of indicators such as emergency hospital admissions, average length of stay, emergency bed days etc. Using this tool for Asthma Table 5.20 has been produced below. This shows better management of Asthma, if Waltham Forest had the same emergency admission rates per 100,000 0 to 18-year-olds as England, there would be a potential saving to the area of £67,308 and similarly if rates were the same as the top 5% in the country, there is a potential saving of £103,339.

Table 5.20 Asthma Disease Management

Tool – Potential cost savings	Waltham Forest PCT	England	Top 25%	Top 5%
Admissions per 100,000 population aged 0–18	355	194	148	108
Cost per admission	£645	£645	£645	£645
Total cost per 100,000 population aged 0–18	£228,886	£125,038	£95,301	£69,446
Potential cost savings per 100,000 population aged 0–18 if rate matches that of England, top 25% or 5% of the country		£133,585	£159,440	£103,848
Potential cost savings – PCT Population aged 0–18 if rate matches that of England, top 25% or 5% of the country		£67,308	£86,582	£103,339

Source: ChiMat data atlas.

There is evidence that educational intervention for children who have attended the accident and emergency department for asthma lowers the risk of the need for future emergency visits and hospital admissions.²⁴⁹ Local information suggests there may be some coding issues when children present (i.e. those presenting with viral wheeze may be coded as asthma), therefore after review of local data, appropriate interventions can be put in place.

School Nursing

The School Nursing service in Waltham Forest support children and young people of school age around health and well-being. The service consists of a Universal School Nursing Service (school nurses covering all non-special schools) and a Specialist School Nurses to support children with additional and complex needs (school nurses based in special schools). The school nurses are the lead professionals in delivering the Healthy Child Programme (HCP) 5–19 years which is based on best evidence to promote and protect the health of children in the developing years.²⁵⁰ A call to action for school nurses has also been published in March 2012 providing a framework for implementation.²⁵¹ The school nursing service locally needs to be reviewed against the HCP 5–19 as well as the call to action, to develop robust specifications to monitor delivery and meet the standards set out.

Young Carers

Involving and consulting young carers has been a major feature of the service enabling us to develop a better understanding of their needs and consequently to provide services that best meets these needs. Extending provision to those young carers not accessing services remains a priority moving forward.

Additionally the local authority aims to:

- Provide young carers opportunities to gain accredited outcomes (including those as young as 8 years old)
- Increase young carer's access to mainstream activities particularly Easter and summer activities
- Facilitate and support the provision of social activities for older young carers aged 16 plus who have left school
- Train staff working with our young carers to NVQ level 4 in Working with Parents in order to increase the quality of support to young carers.
- Complete Family CAFS for young carers where appropriate to help identify needs and provide support for the whole family which will better support the needs of the young carer
- Commence early planning for young carers transitioning to adult services to ensure that they get the right support when they become adults.

Domestic Violence

Children who witness domestic violence are more likely to develop behavioural difficulties, emotional and mental ill-health in adulthood. Assessments of risk to children affected by domestic violence are a critical part of safeguarding practice in Waltham Forest. Effective processes exist for the identification and referral for assessment of children affected by domestic violence. Multiagency public protection arrangement (MAPPA) processes are used to manage adults who pose a risk to the community. Multi-agency risk assessment conferences (MARAC) also take place regularly. There are a number of services locally providing advice, information and practical support for victims of domestic violence. However, there is a lack of specialist services for children who affected.

²⁴⁹ Boyd M *et al.* (2010) Interventions for educating children who are at risk of asthma-related emergency department attendance (Review). The Cochrane Library. <http://www.thecochranelibrary.com/userfiles/ccoch/file/CD001290.pdf>

²⁵⁰ Healthy Child Programme 5–19 years (2009). Department of Health. available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107566

²⁵¹ Getting it right for children and young people (2012). Department of Health. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133011

A report by CAADA titled 'Saving money saving lives' found that of all domestic violence cases, high risk domestic violence accounted for the greatest cost to agencies such as the police, local authorities and the health service at approximately £20,000 per high risk victim. Focusing on these high risk victims through a MARAC process found that for every £1 spent on MARACs £6 of public money can be saved annually. Therefore MARACs would only need to be successful in 16% of cases to pay for themselves.²⁵²

Children and Young People

Other issues related to children and young people and maternal health are available in the following chapters of the JSNA.

- Obesity
- Drugs
- Alcohol
- Tobacco
- Deprivation/Child Poverty
- Domestic Violence
- Sexual Health.

²⁵² Co-ordinated action against domestic abuse – (CAADA) is a national charity supporting a strong multi-agency response to domestic abuse. Their work focuses on saving lives and saving public money.

6

Long-term conditions

6.1 Diabetes

Executive summary

- Diabetes is one of the most significant long-term conditions in Waltham Forest, which can lead to a number of other serious conditions such as heart disease, stroke and chronic kidney disease
- It is expected to continue to be a significant health issue in Waltham Forest as the local population ages and risk factors continue to increase
- People of South Asian origin are at the highest risk of developing diabetes with black ethnic groups also having a higher risk compared their white counterparts
- Registered prevalence of diabetes in Waltham Forest (2009/10 and 2010/11) across GP practices in Waltham Forest is 5.9%, above the national average. Waltham Forest had 13,214 patients registered in 2010/11
- Estimated prevalence is 8.2% which is predicted to increase up to 11.1% due to changing socio-demographic predictions locally. These estimates indicate that there is also an estimated 6,550 adults with undiagnosed diabetes
- There are differences in the systematic, strategic prevention activities for adults with Type 2 diabetes
- NHS Health Checks Programme is a significant opportunity to identify people early with pre-diabetes as well as established diabetes
- Insufficient capacity of Diabetes Specialist Nurses in Waltham Forest and inadequate provision of systematic, culturally appropriate structured patient education with equitable access on diabetes
- There is variation in quality of care across GP practices in Waltham Forest with a number of practices delivering highest quality of care
- Lack of clear guidance to manage housebound patients is an unmet need
- The work is in progress through the diabetes network to redesign the local diabetes care pathway (as a priority) to ensure timely detection, integration across care settings and to improve equity, quality, clinical and cost effectiveness of care
- Examine ways to improve supporting children and young people during the transitional period of diabetic care.

Recommendations

- Further strengthen the capacity of Diabetes Specialist Nurses (DSNs) to improve equitable and culturally appropriate provision of structured education together with innovative publicity to improve uptake
- Commission more dynamic and proactive community programmes that address modifiable risk factors, such as physical activity and diet and encourage more local uptake

- Implement the NICE Public Health Guidance 35 (May 2011) on prevention to reduce the demand due to predicted huge growth in the number of people with diabetes; ensuring more targeted Stop Smoking Services to all diabetes patients and establishing a robust obesity care pathway
- Redesign the local diabetes care pathway (as a priority) to ensure timely detection, integration across care settings and to improve equity, quality, clinical and cost effectiveness of care

Explore ways to improve detection of depression among patients with diabetes and improve the provision of psychological support for patients with diabetes.

- Ensure Stop Smoking Services are accessible to all diabetes patients through active identification of smokers and referral into the NHS Stop Smoking Services
- Establish links with all risk factor (obesity) and co-morbidities (CVD) pathways to provide a well-integrated service to patients with diabetes
- Undertake further analysis of exception reporting to improve quality of care and reduce variation
- Undertake an evaluation of family barriers to comply with treatment plan for children with diabetes Type 1 to plan appropriate interventions to improve control of diabetes.

What is Diabetes?

Diabetes mellitus is a condition in which the amount of glucose in the blood is too high because the body cannot use it properly. There are two main forms of diabetes: Type 1 diabetes mellitus (T1DM) occurs when the pancreas produces no insulin. Type 2 diabetes mellitus (T2DM) develops when the pancreas does not produce enough insulin. Type 2 is the more common in the population and accounts for around 90% of cases of diabetes²⁵³.

More than 500,000 who have T2DM in the UK are not aware of it. It is estimated that by 2025 there will be more than four million people with diabetes in the UK. Most of these cases will be T2DM diabetes, attributable to an ageing population, changing ethnic mix and rapidly rising numbers of overweight and obesity. Recent estimates show that 10% of NHS spending goes on diabetes – that is £9 billion a year or £1 million an hour ^{254, 255}.

Why is diabetes important?

Poor control of diabetes can, in the short term, result in diabetic ketoacidosis, and a potentially fatal medical emergency. In the longer term, poor diabetic control increases the risk of complications such as heart attacks, stroke, blindness, kidney failure and amputation. Studies have shown that good diabetes control is associated with a reduced risk of these complications developing. On average diabetes reduces life expectancy by more than 15 years for someone with T1DM and up to ten years for T2DM.

Around half of people with diabetes have cardiovascular or other types of complications at diagnosis, suggesting that they already have had the condition for up to ten years. Undiagnosed diabetes, presenting as an acute emergency, contributes to the need for unscheduled emergency care and acute admission.

Diabetes related accident and emergency (A&E) attendances and hospital admissions have huge implications on the local health and social care economy²⁵⁶.

²⁵³ Harris M.I. Definition and Classification of Diabetes Mellitus and the Criteria for Diagnosis. In, Diabetes Mellitus, a Fundamental and Clinical text. 3rd Edition. LeRith D., Taylor S.I. and Olefsky J.M. Eds. Lippincott Williams and Wilkins, USA, 2004. P. 457-462.

²⁵⁴ Diabetes UK (2008), A report from Diabetes UK, October 2008: Diabetes. Beware the silent assassin.

²⁵⁵ APHO Diabetes Prevalence Model Findings for England, Yorkshire and Humber, Public Health Observatory; www.yhpho.org.uk

²⁵⁶ Diabetes Guide for London, HealthCare for London, <http://www.healthcareforlondon.nhs.uk/assets/A4diabetesHfL.pdf>

Risk factors for diabetes

Diabetes is most prevalent among those who are overweight or obese, who have a family history and among smokers. People of South Asian origin are up to six times more likely, and those of black African-Caribbean origin up to five times more likely, to develop diabetes compared to white people. Data suggests that 20% of the South Asian community and 17% of the black African and Caribbean community living in the UK have Type 2 diabetes in contrast to 3% of the general population. For those with diabetes other health outcomes are much higher, especially heart disease (2 to 3 times higher in South Asians), renal failure (4 times higher in Asians) and stroke (3 times higher in African-Caribbeans)²⁵⁷.

Socio-economic deprivation is associated with increased risk of diabetes, with the most deprived people at two and a half times greater risk and the risk²⁵⁸ increases with age in both sexes. These are particularly relevant to Waltham Forest, considering its ethnic mix, high level of deprivation and higher level of physical inactivity and overweight/obesity.

Lifestyle behaviours such as physical inactivity and smoking increase the risk of developing Type 2 diabetes and the risk of diabetic complications²⁵⁹.

Smoking is known to increase the risk of diabetes related complications such as heart disease, stroke, and kidney disease. Diabetic retinopathy deteriorates more rapidly in smokers compared to non-smokers.

Obesity is a leading risk factor for diabetes. In Waltham Forest, a quarter of all adults (25%) are estimated to be obese.

Local picture

In Waltham Forest, diabetes is a significant long-term condition both in respect of prevalence and associated morbidity and mortality. Current diabetes prevalence is estimated at 5.9% but it is predicted to rise to over 10% by 2030 due to changes in socio-demographics. A predicted faster rate of growth among the over-50's, coupled with a higher rate of growth among black, asian and minority ethnic (BAME) group in this age cohort in comparison to their white counterparts, are likely to contribute to this increase²⁶⁰.

The modelled prevalence of diabetes for Waltham Forest and for England is 8.2 (16,657 people), and 7.3% respectively. It is predicted that by 2030, Waltham Forest and national prevalence will go up to 11.1% (22,548) and 8.8% respectively²⁶¹.

Women with diabetes are 2 to 3 times more likely to have a baby with a congenital abnormality (birth defect) and 5 times more likely to experience a stillbirth than a woman without diabetes. Preconception care can reduce these risks²⁶². In Waltham Forest, in 2009, it was estimated that 2.5% of women between the ages of 16 and 44 had pre-gestational diabetes. This is higher than London (2.2%) and England (1.8%) estimates and equates to approximately 83 births²⁶³.

²⁵⁷ Diabetes UK (2006), Diabetes and the disadvantaged: reducing health inequalities in the UK; World Diabetes Day 14 November 2006, A report by the All Parliamentary Group for Diabetes and Diabetes UK, http://www.diabetes.org.uk/Documents/Reports/Diabetes_disadvantaged_Nov2006.pdf

²⁵⁸ Diabetes Guide for London, HealthCare for London, <http://www.healthcareforlondon.nhs.uk/assets/A4diabetesHfL.pdf>

²⁵⁹ Bazzano, L A., Serdula, ML, Prevention of Type 2 Diabetes by Diet and Lifestyle Modification, J Am Coll Nutr 2005 24: 310-319 <http://www.jacn.org/cgi/reprint/24/5/310>

²⁶⁰ GLA Round Ethnic Group Projections (Revised), August 2010.

²⁶¹ APHO Diabetes Prevalence Model, <http://www.yhpho.org.uk/resource/view.aspx?RID=81090>

²⁶² Diabetes NHS Areas of Care, Pregnancy 2011. Available from: <http://www.yhpho.org.uk/default.aspx?RID=81090>

²⁶³ APHO Estimates of births to women with pregestational diabetes, 2009.

Registered prevalence of diabetes in Waltham Forest (2008/09 and 2009/10)

As of end March 2010, there were 12,233 people aged 17 and over with diabetes (both Type 1 and Type 2) in all 46 GP Practice registers in Waltham Forest which increased to 13,214 in 2011/12. This equals a prevalence of 5.9% in both years, higher than the prevalence recorded nationally and in London²⁶⁴ during both years. However, this is lower than the estimated prevalence of 8.6% and indicates that there is also an estimated 6,550 adults with undiagnosed diabetes.²⁶⁵

The most recent confirmed prevalence figures in Waltham Forest are shown in Table 6.1

Table 6.1 Registered prevalence of diabetes in Waltham Forest (QOF data 2011/12)

Locality	Diabetes register 17+	Prevalence %
Chingford	2,780	5.5%
Leyton Leytonstone	5,250	6.0%
Walthamstow	5,561	6.1%
Waltham Forest(total)	13,591	5.9%

The highest prevalence was observed in Walthamstow 6.1%, with Leyton Leytonstone reporting 6.0% and Chingford 5.5%.

Type of diabetes in Waltham Forest

Table 6.2 shows where patients identified by secondary care are not found on the primary care diabetes register. The figures are only for data relating to the 45 practices (out of 46) participating in the National Diabetes Audit (NDA) 2009/10 and explains the discrepancy in the number 12,233 reported above for 2009/10 and 12,128 in Table 6.2.

Table 6.2 Diabetes registrations by type for Waltham Forest PCT

	NDA Registrations (Total number of registrations)
Type 1	849
Type 2	10,924
All diabetes *	12,128

*All diabetes include MODY, other specified and unspecified

This indicates that Type 1 diabetes represents 7% of the total population with diabetes registered in Waltham Forest.

Mortality

In 2008–10 period, the directly age standardised mortality rate from diabetes for all ages was 8.42, higher than London (5.82) and England (5.68). Waltham Forest was ranked fourth highest in London²⁶⁶. The estimated percentage of deaths attributable to diabetes among people aged 20 to 79 in Waltham Forest was 14.6%, which was higher than Outer North East London (13.5%) and national (11.6%) rates²⁶⁷.

²⁶⁴ QMAS database data as at year ends. Copyright © 2007; 2008; 2009; 2010; 2011 The Health and Social Care Information Centre, Prescribing Support Unit.

²⁶⁵ Diabetes Profile 2013.

²⁶⁶ Compendium of Health and Clinical Indicators, January 2012. Available from: <https://indicators.ic.nhs.uk/webview/>

²⁶⁷ London Health programme 2009 Health Need Assessment Toolkit <http://hna.londonhp.nhs.uk/JSNA.aspx>

Diabetes prevention

Studies have shown that lifestyle interventions, particularly those targeted at reducing obesity can prevent or delay Type 2 diabetes²⁶⁸. Within Waltham Forest, there is no specific diabetes prevention programme. However, there are population health improvement programmes such as increasing physical activity, healthy eating and reducing overweight and obesity, which all contribute towards diabetes prevention.

Screening for diabetes

There is no systematic screening programme in Waltham Forest for Type 1 or Type 2 diabetes. Screening is performed at GP Practices based on need or through the NHS Health Check Programme or as part of registering new patients to the practice.

Establishing diabetes risk register to monitor those who may be at risk of developing diabetes in the future will enable appropriate follow up of those identified at risk.

Management of Type 2 diabetes in Waltham Forest

Type 2 diabetes patients are mainly managed by primary care. A number of quality and outcome (QOF) indicators are in place under the General Medical Services (GMC) contract. QOF provides financial incentives for GP practices to achieve targets in a number of domains including clinical care. This data can be used to provide information on a number of indicators of clinical outcomes in people with diabetes. A tool developed by Diabetes Health Intelligence and Yorkshire and Humber Public Health Observatory²⁶⁹ allows diabetes care intermediate outcomes in Waltham Forest to be compared with national, regional or the 'Blue Group'. Waltham Forest falls within the 'Blue Group' which has a young population with average deprivation and slightly higher than average population from black and Asian ethnic groups²⁷⁰.

Management of diabetes by CCG level 2011/12²⁷¹

Primary care has a key responsibility to ensure adequate control of blood glucose (measured through HbA1c), blood pressure and cholesterol among people with diabetes. Further, in order to reduce lifestyle related risk factors patients need to be appropriately referred to stop smoking services, exercise and weight management programmes.

Inadequately controlled blood glucose and other risk factors increase the risk of patients developing complications such as heart disease, stroke, kidney damage, visual impairment.

Figure 6.1 provides a breakdown of the key aspects of clinical management of patients with diabetes and highlights the attainment of HbA1c, blood pressure and cholesterol targets in the 15 months ending March 2012.

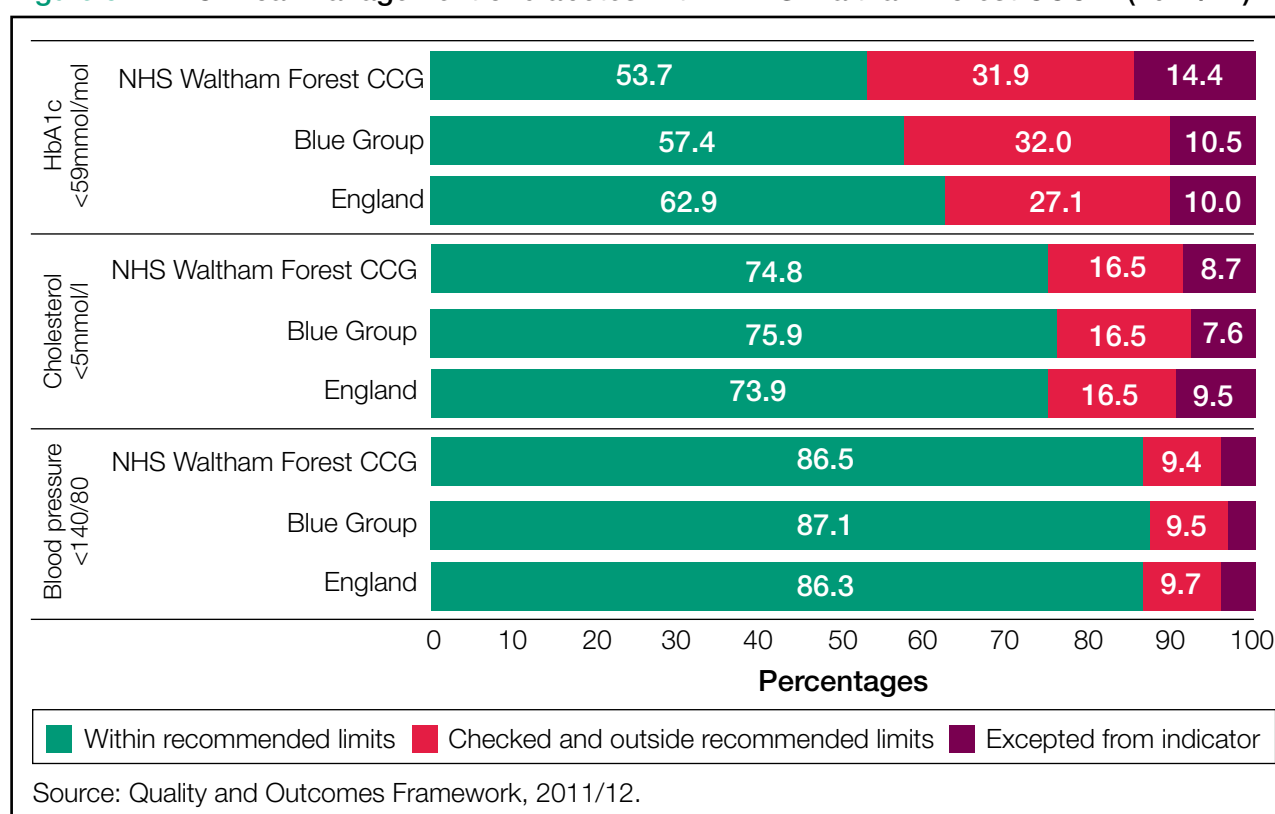
Overall performance is within recommended limits. However, the exception reporting for HbA1c indicators is above that of blue cluster group and England.

²⁶⁸ NEW England Journal of Medicine article.

²⁶⁹ APHO Diabetes Prevalence Model Findings for England, Yorkshire and Humber, Public Health Observatory; www.yhpho.org.uk

²⁷⁰ Diabetes Community Health Profile (2010/11) YHPHO.

²⁷¹ Diabetes Profile 2013 (Although CCGs only came into existence in April 2013, the data for 2011/12 provided by YHPHO Diabetes Profiles was presented by CCG, rather than by PCT).

Figure 6.1 Clinical management of diabetes within NHS Waltham Forest CCG²⁷² (2011/12)

Other conditions related to diabetes

People with diabetes are twice as likely to have depression as the general population. Clinical depression and people with depression are more likely to neglect their diabetes self-care, have worse physical symptoms, worse glycaemic control, increased risk of complications and have two to five times increased mortality. In addition, diabetics with depression have significantly higher medical costs than those without depression. Mental health treatments such as psychological treatments and antidepressants can improve depression outcomes. GP registers for depression among patients with CHD and/or diabetes indicate that the number of CHD and/or diabetes patients with depression increased from 15,253 in 2010/11 to 15,631 in 2011/12, an increase of 2.5%.²⁷³

Diabetes-related foot care contributes to a significant amount of hospital stays. In Waltham Forest, diabetic foot disease accounted for 4,718 nights in hospital between 2008/09 and 2010/11. The incidence of major amputations between April 2008 and March 2011 was 0.67 per 1,000 adults with diabetes, which was significantly lower than the national average of 1.01 per 1,000. During the same time period, the incidence of minor amputations was significantly lower than the national average: 0.92 per 1,000 adults with diabetes compared to 1.66 per 1,000 in England²⁷⁴.

Exception reporting of QOF data

When reviewing a practice's achievement on any given measure, some patients may be excluded from calculation, so-called 'exception' patients. Valid reasons for exception include, the treatment was clinically inappropriate; the patient did not attend or refused treatment, or the patient was only recently diagnosed or registered with the practice²⁷⁵. Further analysis of patients who are exception reported is needed in order to identify this cohort of patients to plan appropriate interventions and to reduce variation across practices.

²⁷² Although CCGs only came into existence in April 2013, the data for 2011/12 provided by YHPHO Diabetes Profiles was presented by CCG, rather than by PCT.

²⁷³ National Diabetes Information Service, Yorkshire and the Humber Public Health Observatory January 2012.

²⁷⁴ *Ibid.*

²⁷⁵ QMAS Guidance.

Morbidity associated with diabetes complications

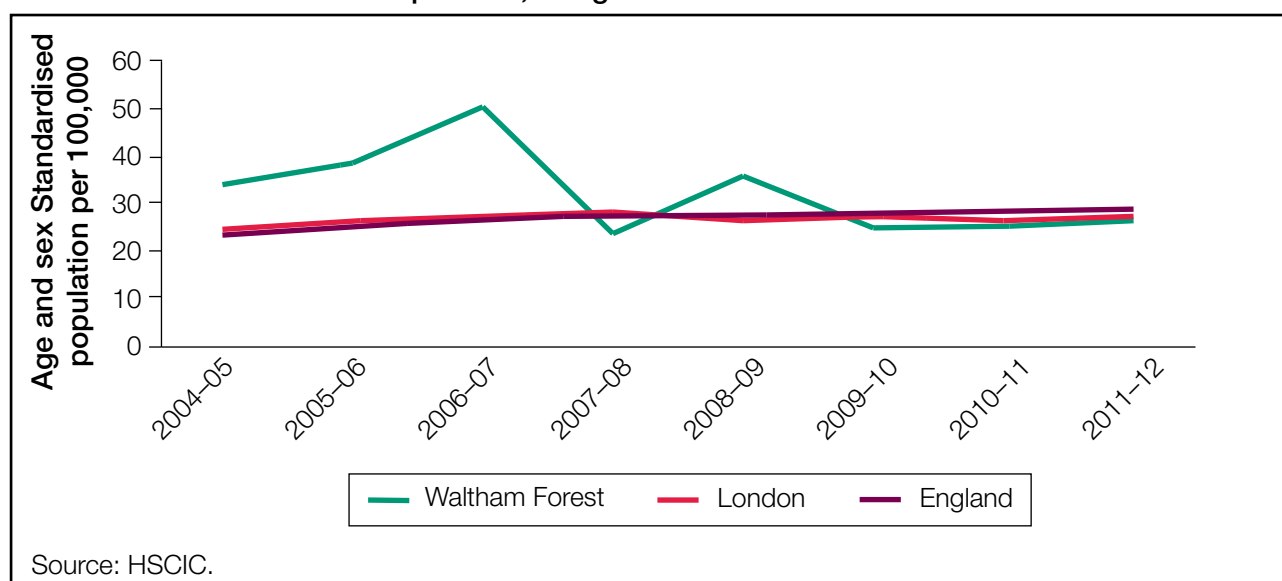
The complications of diabetes are the final outcomes of care. Of all aspects of diabetes they have the greatest costs to the patient and the health service. Achievement of treatment targets reduces the risk of developing complications. Apart from diabetic keto – acidosis (DKA) in Type 1 diabetes, which is an immediate consequence of treatment failure, the other complications arise only after many years of exposure to high blood glucose, blood pressure and high cholesterol. The prevalence of complications has been assessed by determining which patients with diabetes identified in the national diabetes audit have had relevant admissions recorded in the Hospital Episodes Statistics database (HES). Data submitted to the NDA from practice and outpatients units are linked to data from the HES. The complication prevalence rate in Figure 6.2 is based on an admission to hospital with one of the listed conditions at any time in the last 5 years, for patients with diabetes from Waltham Forest.

Emergency admission rates for diabetic ketoacidosis and coma

It is important to note that indirectly age and sex standardised emergency admission rates for diabetic keto-acidosis and coma in Waltham Forest are lower than for England, London and statistical comparators except for Enfield (23.9 vs 21.03 per 10,000). The reduction from 2008/09 to 2009/10 is more marked in Waltham Forest.²⁷⁶

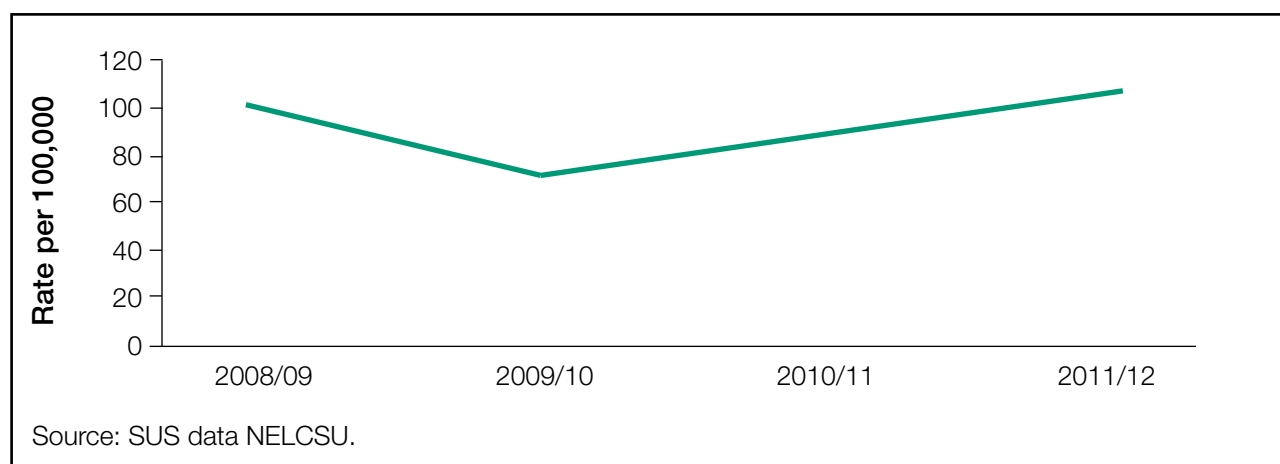
As shown in Figure 6.2, there is a clear downward trend in the admission rates in Waltham Forest although there is slightly upward trend nationally and in London. Fluctuations observed in Waltham Forest are likely to be due to a small sample size.

Figure 6.2 Age and sex standardised emergency hospital admissions: diabetic ketoacidosis and coma – trend in persons, all ages



²⁷⁶ Compendium of Health and Clinical Indicators, January 2012.

Figure 6.3 The trend of diabetes emergency admission rates for 18+ in Waltham Forest from 2008/09 to 2011/12



After a decrease from 2008/09 to 2009/10 the emergency admission rates for all ages in Waltham Forest has been steadily increasing steadily since 2009/10 to 2011/12. The admission rate was highest in 2011/12.

The diabetes emergency admission rate was highest among people over 80 years of age from 2008/09 to 2011/12 except in 2009/10. The rate among that age group decreased slightly since 2010/11 with the exception of children under 15 years, admission rates for the other age groups rose over this period.

Diabetes related foot complications in Waltham Forest

According to NICE guidelines, 20 to 40% diabetes patients have neuropathy and 20 to 40% have peripheral vascular disease. Approximately 5% develop a foot ulcer in any year and amputation rates are 0.5%²⁷⁷. 15% of patients with diabetes will develop a foot ulcer in their lifetime and at any one time, it is estimated that 1.4% will have a foot ulcer²⁷⁸.

The incidence of major amputations in Waltham Forest is currently above the national average this has been below the national average previously. A diabetes foot care audit²⁷⁹ indicates that between 2008/09 and 2010/11, there were 14.2 episodes of care per 1,000 adults with diabetes with foot complications each year, significantly lower than the national rate of 18.1 per 1,000. However, the average number of nights spent in hospital for each episode of care was slightly above the national average of 9.5.²⁸⁰

²⁷⁷ NICE, Type 2 Diabetes. Prevention and management of foot problems. 2004.

²⁷⁸ Edmonds, M., Diabetic foot ulcers: practical treatment recommendations. *Drugs*, 2006. 66(7): p. 913-29.

²⁷⁹ NICE, Type 2 Diabetes. Prevention and management of foot problems. 2004.

²⁸⁰ National Diabetes Information Service, YHPO, January 2012.

Hypertension

Hypertension is another term for consistent high blood pressure. There is evidence that there is increased prevalence of diabetes in patients with hypertension, with one large study showing those with hypertension are 2.5 times more likely to develop diabetes than those with normal blood pressure²⁸¹. Diabetes is known to increase the risk of hypertension. Estimates of hypertension prevalence in diabetes patients range from 35%²⁸² to over 70%²⁸³, depending on the populations studied and the definition of hypertension used. Uncontrolled high blood pressure leads to complications such as kidney damage and visual impairment.

Microalbuminuria

Microalbuminuria is the presence of protein in urine and indicates how well the kidneys are functioning. Poor kidney function is a common progressive condition. Microalbuminuria is present in 12% of Type 2 diabetes patients at diagnosis. Approximately 25% of Type 2 diabetes patients have microalbuminuria²⁸⁴, which equates to 3,000 patients in Waltham Forest.

Diabetes and mental health

People with diabetes are twice as likely to have depression as the general population and clinical depression and people with depression are more likely to neglect their diabetes self-care, have worse physical symptoms, worse glycaemia control, increased risk of complications and have two to five times increased mortality.

In addition, diabetics with depression have significantly higher medical costs than those without depression. Mental health treatments such as psychological treatments and antidepressants can improve depression outcomes. There are two QOF indicators relating to depression in patients with diabetes (see mental health section).

Structured education for patients with diabetes

Patient education and empowerment is crucial for self-management of diabetes. Waltham Forest has adopted the XPERT model that meets NICE criteria for structured education. This service is provided by Diabetes Specialist Nurses (DSNs). The delivery as well the uptake of this service has been consistently poor and this has been a high priority by the CCG and initiatives are in process to meet the immediate and long-term needs of this service.

Diabetes Eye Screening Programme (DESP)

The aim of screening for diabetic retinopathy (eye disease) is to decrease the incidence of visual impairment in the local community. The national screening committee requires an annual retinopathy screen for all patients with diabetes aged over 12.

A central call-recall register is in place to ensure that all patients who have diabetes are identified and appropriately invited for screening. This needs close working between primary care, community eye screening service and acute trust to ensure patients have equitable access and quality of care in the screening cycle.

²⁸¹ Gress TW *et al.* The atherosclerosis risk in communities S. Hypertension and antihypertensive therapy as risk factors for Type 2 diabetes mellitus. *N Engl J Med.* 2000. 342 (13): 905-912.

²⁸² Hypertension in Diabetes Study (HDS): I. Prevalence of hypertension in newly presenting Type 2 diabetic patients and the association with risk factors for cardiovascular and diabetic complications. *J Hypertens.* 1993. 11(3): 309-17.

²⁸³ Colhoun, H.M., *et al.*, The scope for cardiovascular disease risk factor intervention among people with diabetes mellitus in England: a population-based analysis from the Health Surveys for England 1991-94. *Diabet Med.* 1999. 16(1): 35-40.

²⁸⁴ Summaries, C.K. Diabetes Type 1 and 2 – screening/managing renal disease. [cited 14.04.09]; Available from: http://cks.library.nhs.uk/clinical_knowledge/clinical_topics/previous_version/diabetes_renal_disease.pdf.

All recorded diabetics within the Waltham Forest area must be screened (photographed) by the screening service yearly unless formally excluded (under hospital care or unable to screen or treat). The National Screening Programme requires that patients are put on very strict timelines for screening, grading images, clinic appointments and treatment. The Screening service is delivered in three centres across the borough. Results are checked and validated by specialist ophthalmologists at Whipps Cross Hospital. If further investigation or treatment is required, patients are seen at Whipps Cross.

At the time of handing over of the Waltham Forest DESP to NHS England in February, there were a number of gaps in the local care pathway in terms of failsafe system and sharing data across the care settings. This has now been resolved by investment by the NHS England to upgrade software, IT and failsafe process.

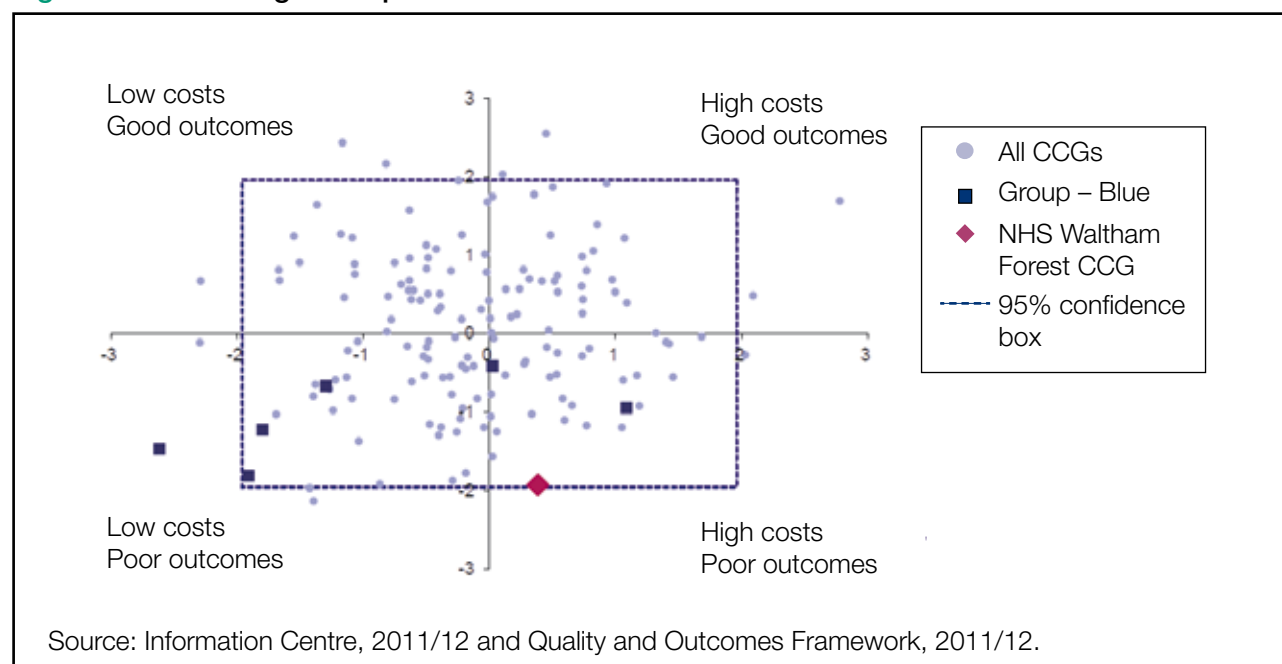
DESP programme board was established in 2013, to oversee the quality and delivery of the local service provision. A business case was developed by Public Health making the case for investment to improve quality and safety.

The External Quality Visit that took place on 19 September acknowledged the progress made to the local DESP. This service now enables clinicians to work in a more coordinated and integrated way to improve access and quality and reduce inequalities and patient outcomes including visual effects relating to DESP.

Programme budgeting total spend per person on the diabetes QOF register in Waltham Forest

NHS Waltham Forest CCG spent a total of £5.5M on prescriptions for diabetes items between April 2011 and March 2012. This was equivalent to £408 per adult with diabetes. Average spending on items to treat diabetes was not significantly different compared to England.

Figure 6.4 Average cost per item for anti-diabetic items NHS Waltham Forest



Evidence of effective interventions

NICE Guidance published in May 2011, provide evidence-based interventions for prevention of diabetes²⁸⁵.

NICE Quality Standards for Diabetes (2011)

In July 2011, NICE published a Quality standard for diabetes²⁸⁶ which provides an authoritative definition of good quality care. NICE quality standards enable the following to happen:

- Health and social care professionals can make decisions about care based on the latest evidence and best practice
- Patients can understand what service they can expect from their health and social care providers
- NHS trusts can quickly and easily examine the clinical performance of their organisation and assess the standards of care they provide
- Commissioners to be confident that the services they commission are high quality and cost-effective.

Type 1 Diabetes Mellitus (T1DM)

Diagnosis and management

Diagnosis of T1DM is more likely to occur in a hospital setting following a patient presenting with the consequences of undiagnosed diabetes, e.g. dehydration, weight loss, diabetic ketoacidosis. Type 1 Diabetes patients are usually managed by the acute trusts. GPs see Type 1 Diabetes patients for insulin dose adjustment or for insulin and needle prescriptions.

Every child newly diagnosed with Type 1 diabetes should be evaluated and cared for by a diabetes team (consisting of a paediatrician with a particular interest in diabetes, a nurse educator, a dietician, and a mental health professional) qualified to provide up-to-date adolescent-specific education and support²⁸⁷.

Nurses dedicated to communicating basic specialised diabetes education skills are required for adolescents. They require management skills within a context that addresses family dynamics and issues facing the whole family.

It is essential that substantial educational material (necessary for basic management, often referred to as 'survival skills') be conveyed to a family of a child with Type 1 diabetes:

- Immediately after the initial diagnosis studies suggest that to be effective, educational interventions need to be ongoing
- Frequent telephone contact, and both in-person care and telephone availability have been demonstrated to improve HbA1c.

Other services and screening for Type 1 diabetes

Children with Type 1 diabetes need to be referred for the following services in order to maximise outcomes related to this condition:

1. Medical nutrition therapy by a registered dietician:
 - As part of initial team education and on referral, as needed.
 - Generally requires a series of sessions over the initial 3 months after diagnosis, then at least annually, with young children requiring more frequent re-evaluations.

²⁸⁵ Preventing Type 2 diabetes: population and community level Interventions, NICE public health guidance35 (guidance.nice.org.uk/ph35).

²⁸⁶ NICE Quality standards for diabetes 2011.

²⁸⁷ HfL and BUPA Report on Diabetes 2010.

2. Diabetes nurse educator:
 - As part of initial team education, or referral as needed at diagnosis; generally requires a series of sessions during the initial three months of diagnosis, then at least annual re-education
3. Behavioural specialist.
4. Depression screening annually for children ≥ 10 years of age, with referral as indicated:
5. Annual screening for microalbuminuria should be initiated once the child is 10 years of age and has had diabetes for 5 years; more frequent testing is indicated if values are increasing:
 - Fasting lipid profile should be performed at the time of diagnosis (after glucose control has been established). If values fall within the accepted risk levels (measurement should be repeated every 5 years).
 - The first ophthalmologic examination should be obtained once the child is 12 years of age and has had diabetes for 3 to 5 years. After the initial examination, annual routine follow-up is generally recommended.
 - Annual foot exams should begin at puberty.

Barriers to managing Type 1 Diabetes among children

A number of factors such as presence of repeated episodes of diabetic ketoacidosis, other health problems (e.g. asthma), poor school attendance, learning disabilities, and emotional and behavioural disorders and depression are barriers to adhere to treatment regime for diabetes among children.

Certain family characteristics have been identified as risk factors for poor diabetes control. These include a single-parent home, chronic physical or mental health problems in a parent or other close family member (including substance abuse,) a recent major life change for the parent (e.g. loss of a job or a death in the family), complex child care arrangements, and health/cultural/religious beliefs that make it difficult for the family to follow current diabetes treatment plans. Therefore early evaluation of family barriers to comply with treatment plan is essential to avoid inadequate control of diabetes.

Working with the patient and family, develop an exercise plan and support package including strategies to measure blood glucose levels, manage hypoglycaemia, adjust carbohydrate intake and insulin doses will enable adequate control of diabetes.

Transition from childhood to adolescence – Type 1 diabetes

Attention to such issues as family dynamics, developmental stages and physiologic differences related to sexual maturity are all essential in developing and implementing an optimal diabetes regimen in adolescents.

Targets of education need to be adjusted to the age and developmental stage of the patient with diabetes and must include the parent or caregiver²⁸⁸.

The goal should be a gradual transition toward independence in management through adolescence. Adult supervision remains important throughout the transition.

Many of the demands of self-care for diabetes interfere with the adolescent's drive for independence and peer acceptance. Peer pressure may generate strong conflicts. In this age-group, there is a struggle for independence from parents and other adults that is often manifested as suboptimal adherence to diabetes care. Evidence shows that adolescents whose parents exercise supervision in the management of diabetes have better metabolic control.

²⁸⁸ BUPA diabetes.

What is being done locally to address this issue?

The Waltham Forest Diabetes Network, local clinical leadership and commissioners will improve care through the implementation of the Diabetes Guide for London service model. This model once in place is expected to reduce acute episodes through more proactive management of diabetes in a primary and community setting through personalised care planning and improved education of patients. A pilot to implement the Year of Care model in 2010/11 provided information on some of the barriers to care planning experienced by patients and clinicians.

Prevention Services

Services to improve physical activity and reduce obesity are available across Waltham Forest. The NHS works with the local authority to provide specialist exercise on referral services for secondary prevention of diabetes. They also work in partnership to provide exercise opportunities for young people and those over the age of 55 who would not normally exercise. A service to improve healthy eating entitled Why Weight uses a whole family approach to tackling weight issues through diet.

Primary Care Services

Local GP practices are monitored on achievement against the nine care processes through the Quality and Outcomes Framework. The Clinical Commissioning Group agreed to adopt a process of accreditation based on the Diabetes Guide for London.

Secondary Care Services

Specialist outpatient and inpatient services have been commissioned to provide care for children and adults with Type 1 diabetes, women with diabetes who become pregnant and who develop gestational diabetes, patients with Type 2 diabetes that have difficulties managing their condition or have established complications. Other specialist services include foot care, renal services, and diagnosis and treatment of diabetes related eye conditions.

Community Care

A specialist community service was commissioned in 2008 to provide specialist care for high need patients outside of hospital. Other services include footcare, dietetic services, and two diabetes nurse specialists service.

Structured patient education is available for Type 1 patients through the DAPHNE course and for Type 2 patients using the XPERT patient programme. From 2011 some staff members have been trained on the Conversation Map patient education programme. Both courses are delivered by the community Diabetes Nurse Specialists Nurses and dietician.

Foot care services are provided across Outer North East London and receive over 100 referrals a week for diabetic and non-diabetic foot care needs. Twenty two podiatrists and three podiatry assistants provide sessions in community clinics, hospital wards and in patients homes.

A review of community services revealed that there is a need to increase the provision of Diabetes Nurse Specialists from 2 to 5 nurses per 250,000 population and the number of dieticians from 3 to 4 per 250,000 population as recommended by national guidance.

What is the public perspective?

Figure 6.5 Percentage of people with a long-term condition that received enough support from local services

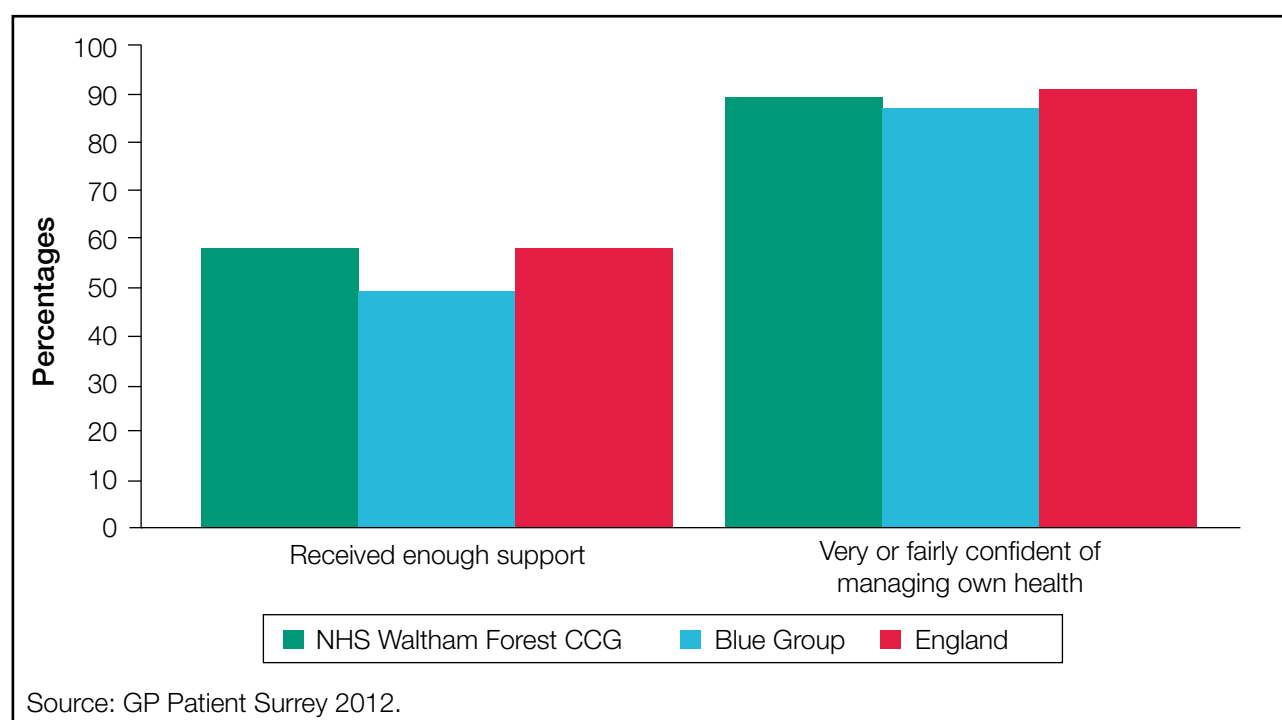


Figure 6.5 shows the percentage of all people with a long-term condition that have received enough support from local organisations and how confident they feel about managing their own health from the GP Patient Survey. However, no separate information available specifically for diabetes.

What more do we need to know?

Challenges

- Variation in the quality of diabetes care in primary care
- Inadequate capacity in the existing structured education programme
- Inadequacy in provision of culturally appropriate structured education programmes
- Lack of a well-integrated diabetic care pathway across primary, community and acute care
- Gaps in diabetic care for housebound patients
- Psychological support continues to be variable across the localities.

Meeting the challenges (Progress)

1. The work is underway to redesign the diabetes care pathway to strengthen integration across care settings, improve quality of care and reduce variation ensuring local needs are met.
2. There is work in progress to provide adequate capacity for provision of structured diabetes education.
3. Plans are in place to establish a robust system to undertake NHS health checks which will enhance case findings of diabetes.

What evidence is there that we are making a difference?

The CCG has identified strengthening staff capacity particularly Diabetes Specialist Nurses' cadre to meet national standards. Action is being taken to recruit into two vacant DSN posts in Waltham Forest.

Work is underway to redesign the local diabetes care pathway to improve integration, effectiveness and productivity and ensure a reduction of variation in quality of care.

Subsequent to taking over of the programme by the NHS England, funding was provided to meet the gaps that existed in the programme. The External Quality Visit that took place on 19 September acknowledged the progress made to the local DESP.

6.2 Cancer

Executive summary

Epidemiology

- Waltham Forest mortality from all cancers is higher than England and London average. We are ranked 14th highest in London
- Under 75 years mortality from cancer is higher than England and London average. It is also higher than our statistical comparators Croydon and Greenwich
- During 2008–10, on average there were 872 new cases of cancer diagnosed in the borough and 375 deaths every year.

Breast cancer

- During 2008–10 the directly standardised incidence rate for breast cancer (DSR) in Waltham Forest was 117.2 which is lower than England average at 124.5 but higher than London average of 116.9
- The 2008–10 pooled data show Waltham Forest directly standardised mortality rate for breast cancer (30.3) for all ages is higher than England (25.3) and London (25.16) average
- Similarly, in 2008–10, breast cancer mortality rate (DSR) for under 75s was 23.56 which is higher than England average at 19.25 and London average of 19.15. Waltham Forest ranked second highest in London.

Cervical cancer

- 2008–10 pooled data show Waltham Forest incidence rate of cervical cancer (9.2) is higher than England (8.71) and London (6.37) average
- Three year pooled data (2008–10) show Waltham Forest directly standardised mortality rate for cervical cancer all ages of 2.06 is equal to London average (2.06) and lower than England average (2.24)
- In the same period (2008–10) mortality rate for under 75 years, shows Waltham Forest rate is higher than London and England average. Waltham Forest was ranked 20th highest in London.

Bowel cancer

- The 2008–10 pooled data for bowel cancer (persons) show that Waltham Forest directly standardised incidence rate of 39.99 was lower than England (47.86) and London (42.95)
- During the same period, Waltham Forest directly standardised mortality rate for bowel cancer was lower than England and London average in both males and females
- Waltham Forest's standardised mortality rate colorectal for under 75 male is above England and London average.

Survival

- Waltham Forest's cancer survival is still one of the poorest in London. Survival rates are also lower than our statistical comparators Croydon and Greenwich
- The key drivers for the poor survival in Waltham Forest are poor awareness of cancer symptoms by the general population, delay in diagnosis and advanced stage at diagnosis.

Screening coverage

- 2011/12 breast screening coverage for women aged 53 to 70 years in Waltham Forest was 71.7%, meeting the national minimum standard of 70%. It is below England average of 77% but higher than London average of 69.3%²⁸⁹
- Breast screening coverage is variable at practice level ranging from 53.3% to 75.1%; only eight practices achieved the minimum standard of 70%
- Cervical screening coverage (25 to 64-year-olds) in 2011/12 was 76%. This is below the national minimum target of 80%, below the England average of 78.6% but higher than London average of 74.1%
- 11 practices out of 45 (24%) achieved the national target of 80% coverage
- In the same period 99% of Waltham Forest women received their cervical screening results in two weeks. This is above the national average of 95% and London average of 94.2%
- In 2013 the Waltham Forest bowel screening uptake average was 43.7%, and none of the GP practices achieved the national target of 60%. The bowel screening uptake at practice level ranged from 27.6% to 55.6%.

Local initiatives

Over 10 projects have been implemented in the last two years that are linked to early diagnosis. This included public awareness of cancer symptoms and advice to see GP without delay through media campaign and community engagement, GP training and provision of early diagnosis tools. Continued investment in promoting early detection of cancer will build on the momentum gained with these projects.

Recommendations

- Continued investment in early diagnosis through targeted community outreach work, GP training and increasing access to diagnostics e.g. flexible sigmoidoscopy and x-ray
- Develop targeted interventions for those who do not participate in screening programmes to increase screening uptake e.g. active follow up of DNAs through telephone calls, text messaging, letters offering second time appointments or recommending screening when eligible persons attend clinics²⁹⁰
- It is estimated that about a third of cancers could be prevented by eating a healthy diet, being physically active and maintaining a healthy weight²⁹¹. Address cancer risk factors such as smoking, obesity, physical inactivity and excessive alcohol consumption
- Implementing age extension for both bowel and breast screening programmes
- Implement systems to facilitate completeness in recording stage of diagnosis.

²⁸⁹ NHS Breast Screening Programme: coverage of women aged 53–70 by Primary Care Organisation, at 31 March 2011 and 2012.

²⁹⁰ Approaches to improving breast screening uptake: evidence and experience from Tower Hamlets; KW Eilbert, K Carroll, J Peach, S Khatoon, I Basnett and N McCulloch; British Journal of Cancer 101(S2), S64 – S67 (2009).

²⁹¹ World cancer research fund – stopping cancer before it starts, <http://www.wcrf-uk.org/> accessed 3/09/2010.

What is cancer?

Cancer is a term used to describe a group of diseases that affect different parts of the body. Other terms used are neoplastic disease or malignancy. Cancer accounts for nearly 30% of all deaths among men and 25% of deaths among women in England every year.²⁹² Cancer remains a high priority in Waltham Forest as the second most common cause of death. Between 2007 and 2009 cancer accounted for nearly 25% of all deaths in the borough²⁹³.

Cancer risk factors

Cancer risk factors can be divided into two broad categories:

1. Fixed risk factors – these are factors that one cannot control. They include:
 - Age: ageing is the primary factor for the development of cancer, for example 85 per cent of breast cancer cases occur in women 50 years of age and above²⁹⁴.
 - Gender: certain types of cancer (e.g. prostate cancer) are gender specific.
 - Family history: research shows that there is an inherited predisposition to cancer for people with family history of cancer. Women who have a family history of breast or ovarian cancer are at a higher risk for breast cancer than those who lack such a history.
2. Modifiable factors – these are factors that one can change as they are related to lifestyle choices.
3. Smoking: smoking causes 9 out of 10 lung cancer cases²⁹⁵. The Waltham Forest estimated smoking prevalence in the general population aged 16+ is 19.3% and 24% in people aged 40 to 74 attending a health check:
 - The death rate from smoking per 100,000 population is 263.3, one of the highest in England²⁹⁶.
 - Obesity: research has shown that many types of cancer are more common in people who are overweight or obese²⁹⁷. Waltham Forest adult obesity rate (model-based estimates) is 20.2% which is higher than London (18.4%) but lower than England (23.6%).
 - Lack of exercise: regular physical exercise has been shown to reduce the risk of breast cancer. A physical activity survey by Sport England in 2007/08 highlighted Waltham Forest's residents have lower levels of physical activity; only 15.5% of residents aged 16 years and over participate in 30 minutes of moderately intense physical activities 3 times a week compared to 16.4% in England and 16.5% in London.
 - Diet: generally a diet rich in fruit and vegetables, high in fibre and low in red meat, processed foods and sugar will contribute to a protective effect against many diseases including breast cancer, bowel cancer etc.

²⁹² London Health Observatory (LHO); Mortality from all cancers (directly age standardised rate per 100,000 population, persons under 75 years) by local deprivation quintile. Metadata. Available at http://www.lho.org.uk/Download/Public/16127/1/Stratified_cancers_under%2075s%20MetaData.doc. Accessed 5/7/2011

²⁹³ National Centre for Health outcome and development (NCHOD); compendium of indicators.

²⁹⁴ Breast cancer UK, <http://www.breastcancercampaign.org/breastcancer/6/> accessed September 2010.

²⁹⁵ Cancer research UK <http://www.cancerhelp.org.uk/type/lung-cancer/about/lung-cancer-risks-and-causes> Accessed Sept 2010.

²⁹⁶ Department of Health Smoking Kills: a white paper on tobacco. London: The Stationery Office, 1998.

²⁹⁷ Cancer research UK <http://info.cancerresearchuk.org/healthyiving/obesityandweight/index.htm?gclid=CLPI8v6T-KMCFQIB4wod5Va9IA> Accessed Sept 2010.

- Alcohol consumption is associated with an increased risk of oral, esophageal, breast, and other cancers. Six per cent of cancer deaths in the UK are caused by alcohol and all of these deaths could be avoided²⁹⁸.
- Other lifestyle and environmental factors known to affect cancer risk include certain sexually transmitted diseases (such as those conveyed by the human Papilloma virus (HPV), exposure to radiation from the sun or from tanning beds and certain occupational and chemical exposures).

The vast majority of cancer risk factors are environmental or lifestyle-related, leading to the claim that cancer is a largely preventable disease ²⁹⁹. <http://en.wikipedia.org/wiki/Cancer> – cite_note-Danaei-34#cite_note-Danaei-34

Local picture

Cancer incidence

There were 872 people diagnosed with cancer annually in Waltham Forest during 2008–10. This represented a 21% increase compared to 2007–09. Between 2008–10 there were 1,799 cancer cases diagnosed in people aged under 75 in Waltham Forest – 927 males and 872 females.

Waltham Forest's directly standardised incidence rate (412 per 100,000 population) for all cancers in all ages between 2008–10 is higher than the England (386.9) and the London average (366.2). Similarly the incidence rate is higher than our statistical comparators Croydon (368.9) and Greenwich (407.3)³⁰⁰.

Mortality from all cancers

The most recent (2008–10) pooled data show there were 1,124 deaths from all cancers in the borough. This is an average of 375 deaths annually. Directly standardised mortality rate (DSR) from all cancers, all ages for Waltham Forest (169.45 per 100,000 population) is higher than England (169.42) and London (161.69) averages. It is also higher than Croydon (151.74) our statistical comparator but lower than Greenwich (180.01). Waltham Forest is ranked 14th highest in London.³⁰¹

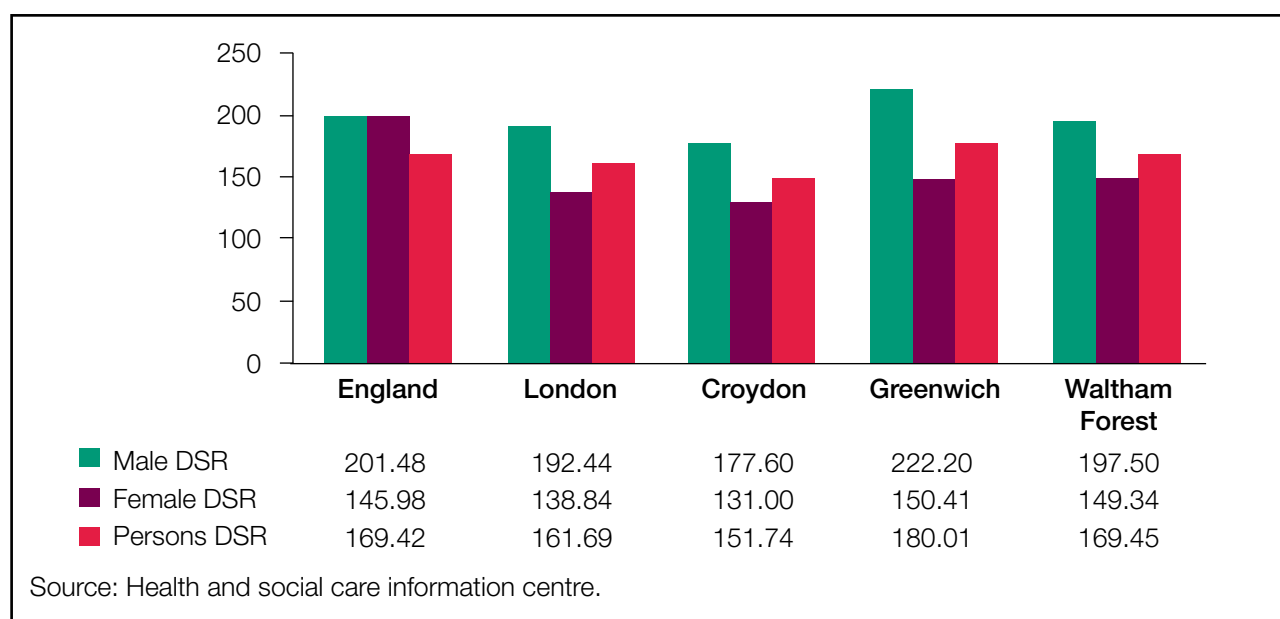
Analysis by gender shows Waltham Forest male DSR is ranked 18th highest in London, it is lower than England average but higher than both London and Croydon average. Female DSR is ranked 9th highest in London and it is higher than England, London and Croydon average but lower than Greenwich. See Figure 6.6 below.

²⁹⁸ Doll, R. and R. Peto, *Epidemiology of Cancer*. Oxford Textbook of Medicine, ed. D. Warrell, et al. 2003, Oxford: OUP.

²⁹⁹ Danaei G, Vander Hoorn S, Lopez AD, Murray CJ, Ezzati M (2005). 'Causes of cancer in the world: comparative risk assessment of nine behavioural and environmental risk factors'. *Lancet* 366 (9499): 1784–93. doi:10.1016/S0140-6736(05)67725-2. PMID 16298215.

³⁰⁰ The NHS Information Centre for health and social care. *Compendium of Population Health Indicators*. January 2013.

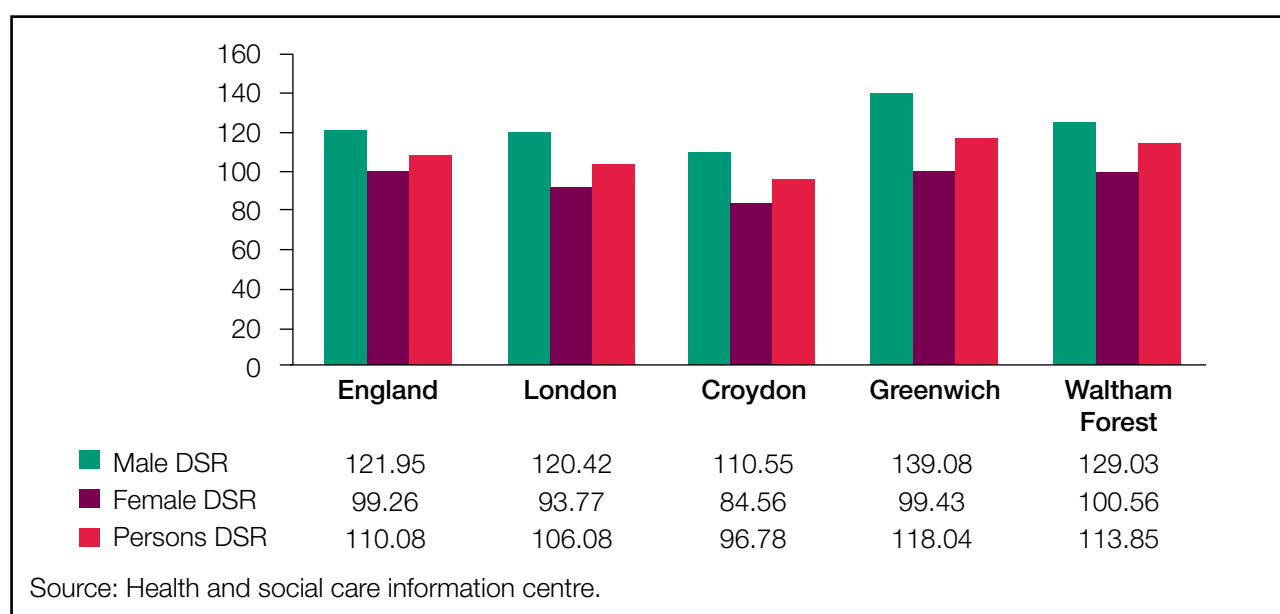
³⁰¹ *Ibid*.

Figure 6.6 Directly standardised mortality rate from all cancers all ages 2008–10 pooled data

Under 75 mortality rate from cancer

2008–10 pooled data show there were 604 premature deaths (less than 75 years) from all cancers in the borough. Waltham Forest directly standardised mortality rate for under 75 years is 113.85 which is higher than England (110.08) and London (106.08) averages. Compared to our statistical comparators it is higher than Croydon but lower than Greenwich. Waltham forest is ranked 12th highest in London.³⁰²

Analysis by gender shows Waltham Forest male DSR is ranked 13th highest in London. It is higher than England, London and Croydon but lower than Greenwich. Female DSR is ranked 9th highest in London and it is higher than England, London, Croydon and Greenwich average. See Figure 6.7 below.

Figure 6.7 Directly standardised mortality rate from cancer under 75 years, 2008–10 pooled data

³⁰² The NHS Information Centre for health and social care. Compendium of Population Health Indicators. January 2013.

Collaborative working with CCG and local authority is vital in ensuring improvement in these outcomes.

Survival

The latest age-standardised relative survival rates for breast, cervical, colorectal and lung cancer in England are for people diagnosed in 2004–06 and followed up until December 2011. Data is not available at borough level but Waltham Forest rate is based on North East London Cancer Network (NELCN) rate. Likewise local one year relative survival rate is estimated from the NELCN average. In all four cancers above NELCN survival rates are below both England and London average and therefore its estimated Waltham Forest survival rates are lower than England and London average.

See Table 6.3 below for more information.

Table 6.3 Breast cancer 1 and 5 years relative survival rate

	1 year survival				5 year survival			
	Breast	Cervical	Colorectal	Lung	Breast	Cervical	Colorectal	Lung
England	94.7%	80.9%	69.4%	28.4%	83.3%	63.3%	51.6%	8%
London	94.9%	80.6%	69.7%	30.5%	82.7%	63.4%	51.3%	9%
North East cancer Network	92.3%	72.6%	66.1%	27.6%	76.6%	52.3%	47%	8.1%

Source: Health and social care information centre.

The key drivers for the poor survival in Waltham Forest are poor awareness of cancer symptoms by the general population, advanced stage at diagnosis and delay in diagnosis. Waltham Forest is addressing these issues as part of the national early awareness and diagnosis initiative.

Poor awareness of cancer symptoms by the general population and delay in diagnosis would suggest reviewing our overall spending to ensure adequate resources for investment in cancer prevention, early awareness and detection work streams.

Cancer Screening Programmes

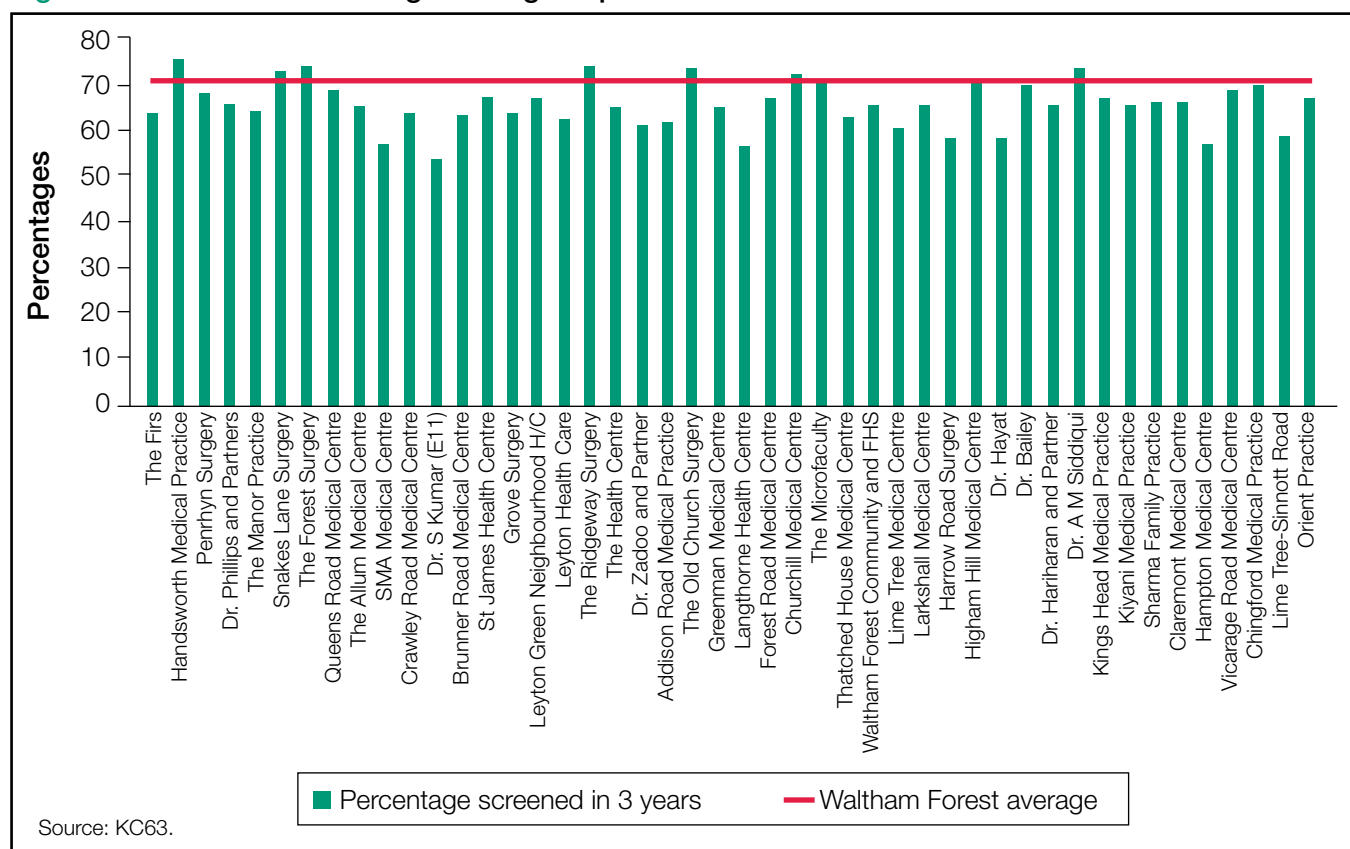
Breast Screening

Waltham Forest screening coverage for 53 to 70 year was 71.7% in 2011/12, meeting the national minimum standard of 70%. This is an improvement from the previous year's coverage of 70.7%. Waltham Forest's coverage is below England average of 77% but higher than London average of 69.3%³⁰³ and ranks 10th best compared to London's 33 boroughs.

Waltham Forest breast screening coverage compared our statistical neighbours is higher than Greenwich but lower than Croydon.

There is a wide variation in breast screening coverage at practice level ranging from 53.3% to 75.1%. Only eight practices had achieved the minimum standard of 70%. The coverage variation is seen in localities with Chingford having the highest coverage in 2011/12 of 70.7% followed by Walthamstow with 65.7% and lowest coverage is in Leyton/Leytonstone areas with 62.5%. This suggests there are inequalities, probably driven by factors related to the locality and residents' age. Chingford area is relatively more affluent with older population compared to Leyton/Leytonstone areas with a more deprived and younger population. See Figure 6.8 below for more information on practice level coverage.

³⁰³ NHS Breast Screening Programme: coverage of women aged 53-70 by Primary Care Organisation, at 31 March 2011 and 2012.

Figure 6.8 Breast screening coverage at practice level

Breast screening age extension (47 to 49 and 71 to 74-year-olds)

Currently people aged 50 to 70 years are eligible for the national breast screening programme. Age extension will increase the age range from 47 to 74 years.

Breast screening age extension for the Waltham Forest has not been implemented as the Provider, Central and East London Breast Screening Service (CELBSS) is not meeting some of the qualifying criteria.

Familial breast cancer

The majority of breast cancer occurs as isolated cases; however about 20 to 30% is 'familial', of which a minority (15 to 20%) is caused by mutations in breast cancer genes such as BRCA1 and BRCA2.

Women with a first degree relative (mother, father, sister, brother, daughter and son) with breast cancer are twice as likely to develop breast cancer themselves and the risk of breast cancer increases with increasing family history. Surveillance of familial breast cancer aims at detecting breast cancer early and has been demonstrated to improve mortality and morbidity.³⁰⁴

³⁰⁴ London Specialised Commissioning Group. Familial Breast Cancer Risk Assessment and Surveillance in London. 2011.

Cancer Reform Strategy, 2009 recommended that:

- Women who are at increased risk of breast cancer (e.g. those with a family history) should be offered risk assessment and extra surveillance, using the existing NHS Breast Screening Programme for follow up
- All women who are currently unaffected with breast cancer but who are concerned about their risk of breast cancer because of a family history should have access to appropriate information, risk assessment and surveillance.

The National Screening Office has requested Breast Screening Units to undertake breast screening surveillance for women at high risk of breast cancer from 2012 and have also agreed a protocol for the surveillance of this group. The London Screening Improvement Board has agreed the London Guidance for the screening of women at increased risk of breast cancer.

Cervical screening

Waltham Forest cervical screening coverage for women aged 25-64 in 2011/12 was 76%, which is a 1% decline from previous year. Waltham Forest coverage is below the national minimum target of 80%, below the England average of 78.6% but higher than London average of 74.1%. The coverage is higher than our statistical comparators Croydon and Greenwich. In general older women (50 to 64) have better coverage than the younger ones (25 to 49) which is similar to national picture, and in 2011/12 the Waltham Forest biggest coverage decline was in the younger women from 70.1% in 2010/11 to 68.9% in 2011/12. See Table 6.4 below.

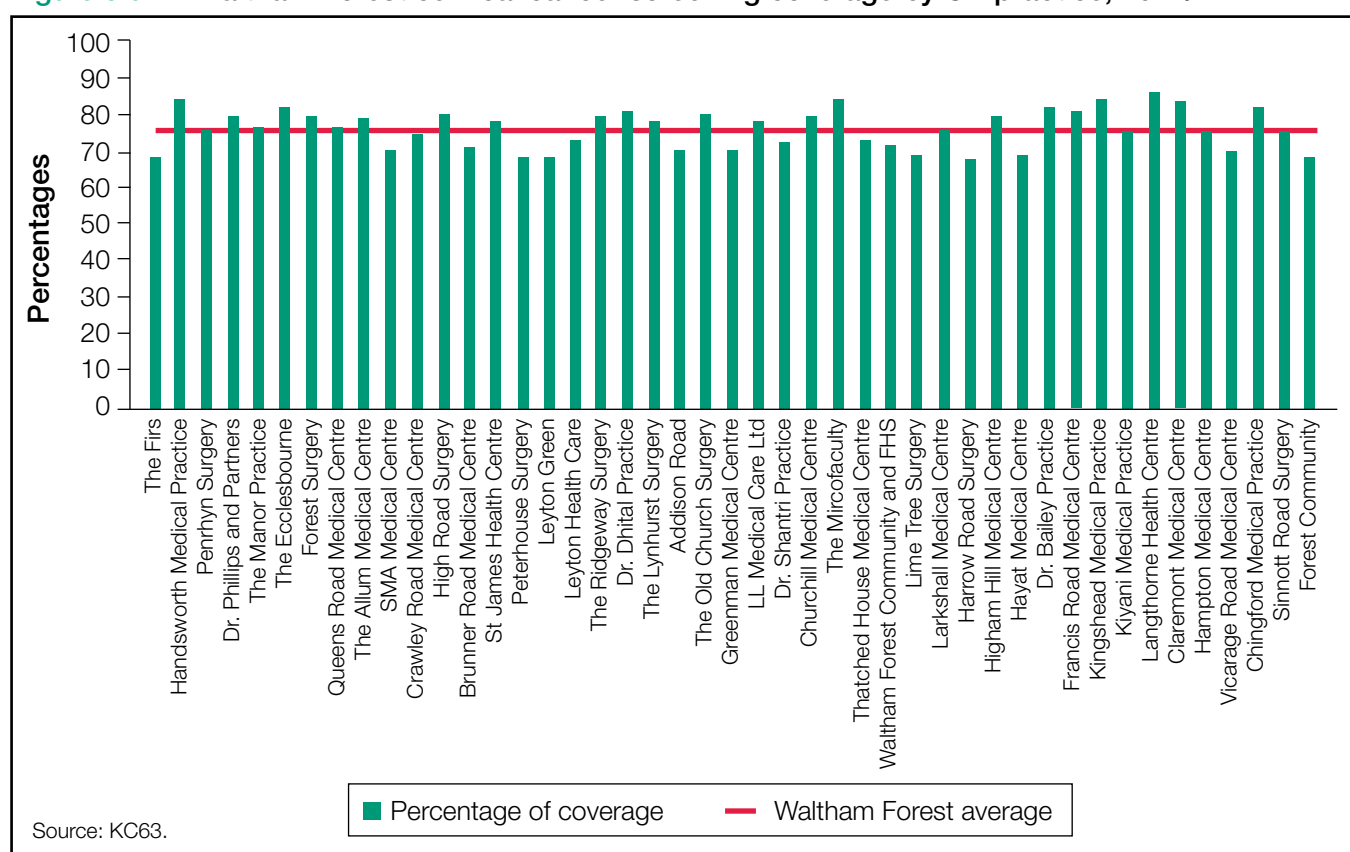
Table 6.4 Cervical screening coverage 2010/11 and 2011/12

Area	Coverage 2010/11			Coverage 2011/12		
	25–49 (Less than 3.5 years. since last adequate test) (%)	50–64 (Less than 5 years. since last adequate test) (%)	25–64 (Less than 5 years. since last adequate test) (%)	25–49 (Less than 3.5 years. since last adequate test) (%)	50–64 (Less than 5 years. since last adequate test) (%)	25–64 (Less than 5 years. since last adequate test) (%)
England	73.7	78.0	78.6	73.5	77.8	78.6
London	67.6	76.0	74.0	67.6	76.0	74.1
Croydon	70.9	77.8	76.6	71.7	78.5	77.7
Greenwich	69.2	73.7	74.7	70.2	74.6	75.7
Waltham Forest	70.7	80.1	77.0	68.9	79.4	76.0

Source: Health and social care information centre

Cervical screening coverage is variable across the borough; only 11 practices out of 45 (24%) achieved the national target of 80% coverage, see Figure 6.9 below.

GPs are central to the delivery of an effective cervical cancer screening programme. General practice can help increase screening uptake by providing more convenient times for appointments, and translating information to women who cannot read English.

Figure 6.9 Waltham Forest cervical cancer screening coverage by GP practice, 2011/12

The Cancer reform strategy³⁰⁵ highlights falling participation in cervical screening for women aged 25 to 35. There is a need to have targeted initiatives to increase screening uptake among this group.

Screening results

In 2011/12, 94.3% of all adequate screens were negative which is higher than national and regional average. Waltham Forest has better outcome in all the categories apart from severe dyskaryosis which is higher than London average, (Waltham Forest 0.6% versus London 0.5%).

Laboratory turnaround time (TAT)

The Cancer Reform strategy 2007 confirmed that by 2010 all women should receive the results of their cervical screening test within 14 days of it being taken. Whipps Cross Hospital Lab has continuously made improvement towards achieving the two week turnaround time target. In 2011/12 99% of Waltham Forest women received their results in two weeks; this is above the national average of 95% and London average of 94.2%.

Inadequate smear rates

Inadequate smears are those where no result can be issued and include those where blood or other matter in the sample makes it impossible to see the cells on the slide properly. Inadequate smears can be caused by not taking enough cells from the cervix to give a result. Whipps Cross laboratory's inadequate rate has continued to decrease and in 2011/12, the inadequate rate was 1.3% which is lower than the national average (2.4%) and London average of 3.4% inadequate smears.

A reduction in inadequate smears reduces anxiety for the women as they are less likely to be recalled for a second test and it also reduces costs to the NHS.

³⁰⁵ Cancer reform strategy. Available on: <http://www.nhs.uk/NHSEngland/NSF/Documents/Cancer%20Reform%20Strategy.pdf> accessed 2/6/2011.

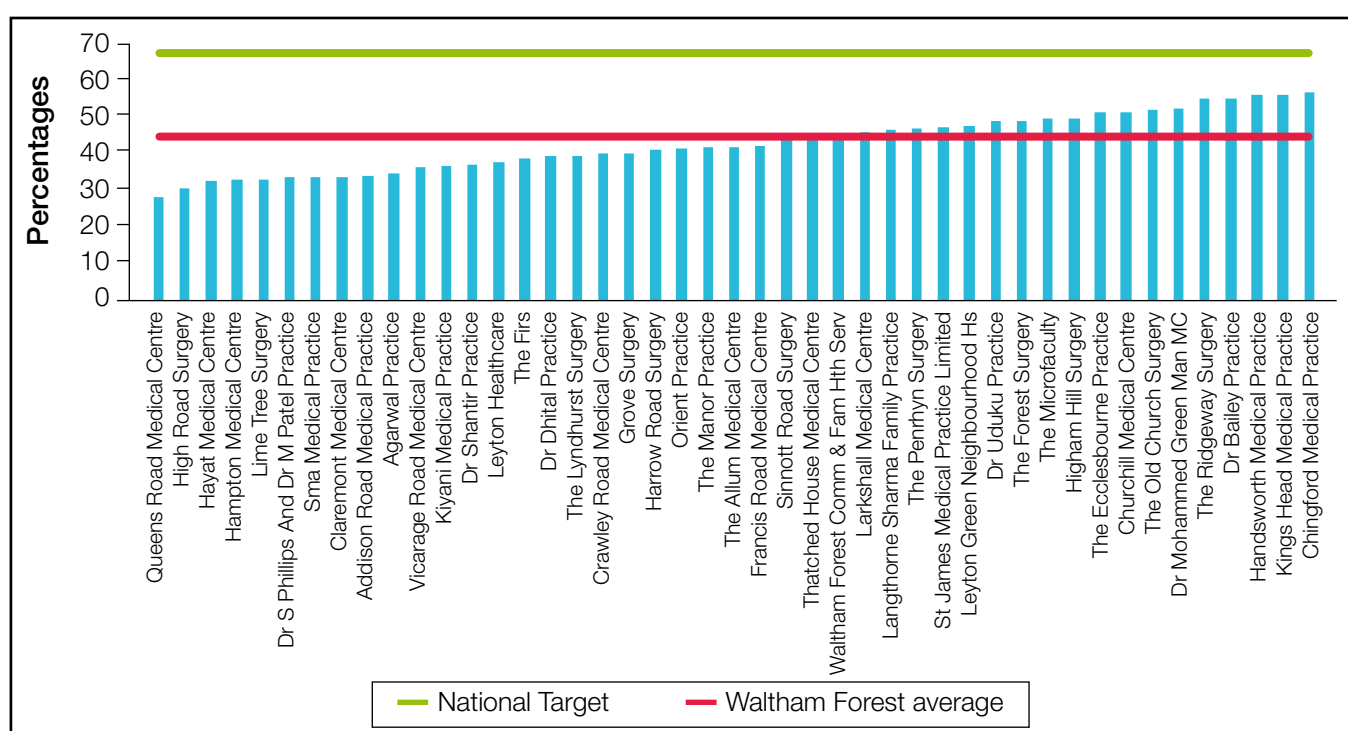
Colposcopy

Whipps Cross colposcopy unit provides services for Waltham Forest. In 2011/12, Whipps Cross colposcopy unit had 150 cases of moderately/severely dyskaryosis which were all seen within four weeks as per national requirement. This is above the national average of 96.4% and London average of 95.4%. Whipps cross performance for two weeks wait for severe and query invasive carcinoma and query glandular neoplasia is 100% which is consistent and well above the national average 94.5% and 92% respectively.

Bowel Screening

Bowel cancer screening uptake has been improving over the years from 36.86% in 2007 when the project was rolled out to 44.18% in 2010/11. Uptake of bowel cancer screening in 2013 was 43.70%. Bowel cancer screening is variable across the GP practices and none of the GP practices achieved the national target of 60%. The bowel screening uptake at practice level ranged from 27.61% to 55.56%. See Fig 6.10 below.

Figure 6.10 Bowel cancer screening uptake by GP practice 2013



Evidence from the bowel screening pilots has shown that uptake of the screening test varies significantly between different groups in the population. Typically, areas with high deprivation and high proportions of minority ethnic groups have the lowest uptake rates. Uptake is also lower among men than among women. Bowel cancer is the second leading cause of cancer death in Waltham Forest, and improved screening uptake could contribute towards early detection of bowel cancer and reducing the number of deaths caused.

Bowel screening age extension (70 to 74 years old)

Currently people aged 60 to 69 years are eligible for the national bowel screening programme. Age extension will increase the age range from 60 to 74 years.

Age extension 'roll out' began in April 2010. The age extension roll out at each screening centre is controlled by the National Office and London Quality Assurance Reference Centre (QARC). The requirements for implementing age extension are:

- The local area has completed two years of screening i.e. they are in the recall phase
- The Screening Centre has demonstrated that they have the capacity to provide the age extended service along with the existing workload in screening and diagnostic service
- The Hub has the capacity to deal with the increased administrative and laboratory work and the necessary space.

In Waltham Forest age extension was due to roll out in 2011/12 but since bowel screening is commissioned as a sector across North East London some sections of the sector did not meet the criteria and London QARC advised that age extension be postponed until the whole sector meets the criteria.

Effective interventions

Overall, the most plausible drivers for improved cancer survival appear to be presentation and diagnosis at an early stage, including through effective screening programmes, access to optimal treatment and improvements in the management of older people³⁰⁶.

Table 6.5 Evidence base for effective interventions

Work area	Interventions
Prevention	Improved outcomes in cancer can be achieved by tackling cancer risk factors such as smoking, obesity, physical inactivity and excessive alcohol consumption. It is estimated that about a third of cancers could be prevented by eating a healthy diet, being physically active and maintaining a healthy weight ³³² .
Screening	<p>Targeted outreach, health promotion and cancer awareness has been shown to be effective in increasing screening uptake:</p> <p>Provision of culturally and linguistically appropriate cancer awareness in targeted venues like grocery shops³³³.</p> <p>Provision of tailored print intervention (newsletter/booklet) and telephone counselling³³⁴.</p> <p>Active follow up of DNAs through telephone calls, text messaging, letters offering second time appointments or recommending screening when eligible persons attend clinics³³⁵.</p> <p>Client reminders, particularly telephone calls³³⁶.</p> <p>Provision of flexible appointment times to meet client needs and easy means to change appointments³³⁷.</p>
Population awareness cancer risk factors and symptoms	The Healthy Communities programme supports community volunteers to work in partnership with primary care staff and other specialist cancer service providers, in both statutory and voluntary sectors, to lead improvement locally. Community members and professionals are taught to use improvement tools to identify what can be changed to make an improvement, and then to measure that improvement. Outcomes include not only improvement in a specific topic area, but benefits to the individual volunteers and to the community itself ³³⁸ .

³⁰⁶ The King's Fund; how to improve cancer survival; available at: <http://www.statistics.gov.uk/CCI/nugget.asp?ID=861&Pos=2&ColRank=1&Rank=144> accessed 08/08/2011.

³⁰⁷ World cancer research fund -stopping cancer before it starts, <http://www.wcrf-uk.org/> accessed 3/09/2010.

³⁰⁸ Sadler GR, Thomas AG, Yen JY, Dhanjal SK, Ko CM, Tran CH, Wang K: Cancer education program based in Asian grocery stores. *Journal of Cancer Education* 2000, 15:173-177. PubMed Abstract | Publisher Full Text.

³⁰⁹ Rimer B, Halabi S, Skinner C, Lipkus I, Strigo T, Kaplan E, Samsa G. Effects of a mammography decision-making intervention at 12 and 24 months. *Am J Prev Med.* 2002; 22:247-257. [PubMed].

³¹⁰ Approaches to improving breast screening uptake: evidence and experience from Tower Hamlets; KW Eilbert, K Carroll, J Peach, S Khatoon, I Basnett and N McCulloch; *British Journal of Cancer* 101(S2), S64 – S67 (2009).

³¹¹ Interventions to increase the uptake of Cancer Screening: Guideline recommendations; M Brouwers, C De Vito, A Carol, J Carroll, M Cotterchio, M Dobbins, B Lent, C Levitt, N Lewis, S E McGregor, L Paszat, C Rand and N Wathen; *Cancer Care Ontario*; 26 March 2009.

³¹² Why Islington women do not attend for breast screening; Dr Edwina Affie; 29 September 2009; Cancer Inequalities Workshop.

³¹³ Lyon D, Knowles J, Slater B and R Kennedy Improving the early presentation of cancer symptoms in disadvantaged communities: putting local people in control.

Best practice early detection commissioning pathways: summary of recommendations

Table 6.6 Ovarian cancer

Recommendation
Due to the risk of false negatives associated with the CA125 test, the London early detection best practice commissioning pathway recommends both Ca125 and trans vaginal ultrasound should be undertaken concurrently with referral to secondary care if either is positive.
If it is not clear where the symptoms originate from, the GP should consider referring along a colorectal pathway.

Table 6.7 Colorectal cancer

Recommendation
Reduction of the threshold age for referring new onset colorectal symptoms from 60 years of age in 2013-2014 to 55.
To reach a rapid definitive diagnosis, GPs should refer the patient to a 'Diagnostic service', a designated referral centre which will triage referrals and assign the most appropriate diagnostic test. This test will be booked directly with the patient.

Table 6.8 Lung cancer

Recommendation
Chest X-Ray reports should be returned to the GP ideally within three days and no more than five working days. GPs should receive a clinic letter containing appropriate information.
It is recommended commissioners refer to the guidance issued by NICE on communication; emphasis on improved communication is included in the updated 2011 NICE guidance.
A lung cancer Clinical Nurse Specialist is available at all stages of care to support patients and carers.
GPs should use every opportunity to discuss smoking with their patient and direct those who want to give up to specialist stop smoking services and/or offer pharmacotherapy to support any quit attempt.
Primary care, secondary care and pharmacy staff to be trained in Very Brief Advice (VBA) for smoking cessation.
All GP surgeries should ensure there is a relationship/links to the local stop smoking service so that smokers can be referred swiftly and appropriately

Table 6.9 Endoscopy commissioning strategy

Recommendation
CCGs should only commission endoscopy from Joint Advisory Group on GI Endoscopy (JAG) accredited providers whether NHS or private sector. Where units are not currently JAG accredited, they must be able to show they are on the journey to achieving JAG accreditation (which can take two years).
Barium enema is not to be used as a first line diagnostic for suspected colorectal cancer.
Surveillance for symptomatic patients must ensure consistent approach to recall of patients so that no patient misses a recall for repeat endoscopy. CCGs should commission repeat endoscopy as per the national guidelines set out by NICE. ³³⁹

³¹⁴ <http://www.nice.org.uk/nicemedia/live/13415/53641/53641.pdf>

What is being done locally?

Local projects

Table 6.10 below provide a summary of the recent and some ongoing cancer projects/initiatives.

Table 6.10 Cancer projects indicate which projects are local/network/national etc. in the table

Name	Provider	Timeframe	Objectives	Comment
Be Clear on Cancer – Bowel Cancer	DH	30 January to end of March 2012	<ul style="list-style-type: none"> • Increase cancer awareness and early presentation. • Contribute to early diagnosis. 	The campaign advertisements featured on TV and the radio and in other national media. The campaign message is that 'loose poo' and 'blood in poo' for more than three weeks can be symptoms of bowel cancer and anyone with these symptoms should visit their doctor; and that catching cancer early makes it more treatable.
Be Clear on Cancer – Lung Cancer	DH	8 May to 30 June, 2012	<ul style="list-style-type: none"> • Increase cancer awareness and early presentation. • Contribute to early diagnosis. 	<p>Adverts on national TV and radio, and in publications aimed at specific communities, for example Asian radio stations. Events in public areas, like shopping centers, to raise awareness and prompt people with possible symptoms to see their GP.</p> <p>Campaign message was if you have a cough for 3 week see your GP.</p>

Name	Provider	Timeframe	Objectives	Comment
Bowel Cancer Screening Awareness Heart in the community	Social Action for Health (SAFH)	April 2012 to March 2013	<ol style="list-style-type: none"> 1. Community Health Champion Recruitment and Training 2. Holding awareness raising stalls 3. Identification of community groups 4. Deliver community awareness sessions 5. Work with clinical teams and GPs to determine their needs around bowel cancer screening and support them in how best to disperse the messages to local people 6. Evaluation of the impact of the intervention 	April – September 2012 the focus has been on delivering the first three delivery objects and setting up plans for the objectives 4-6 to be delivered in October 2012 – March 2013
Bowel stretch campaign	BIG Bowel	Sept 2012 to March 13	<p>Raise awareness of bowel cancer</p> <p>Increase uptake of screening</p> <p>Increase early diagnosis</p>	Deliver two events: in Leyton Orient Football Club Selborne mall
	Age UK			Deliver six small events in the community
Be clear on cancer	DH	Jan 2012	Raise awareness in bowel and lung cancer and increase early diagnosis	

Name	Provider	Timeframe	Objectives	Comment
Know 4 sure	DH	Jan 2013	Raise awareness in all cancers Increase early diagnosis	Work with GPs and pharmacies
Practice Visit	CRUK	Ongoing	Cancer Research UK (CRUK) primary care engagement facilitator for Waltham Forest visit practices to embed best practice in cancer screening and engage clinicians in early diagnosis.	

National cancer outcome indicators

Cancer outcomes are mentioned as indicators in both the NHS and public health outcomes framework. This includes:

- Public Health Outcomes Framework:
 - Cancers diagnosed at stage 1 and 2
 - Mortality from cancer.
- NHS Outcomes Framework:
 - Under 75 mortality rate from cancer
 - One and five-year survival from all cancers
 - One and five-year survival from breast, lung and colorectal cancers.

Risks to local delivery

With the restructuring of the NHS the main risk to service delivery is financial constraints and loss of staff. The merging of Whipps Cross with Barts Health will also influence how services are commissioned and delivered in the future; which might include some of local services being provided in a more centralised location.

Priorities for the next five years

The priority for cancer commissioning should be to improve survival through early presentation and early detection. This is a three pronged approach:

1. targeting the public to increase awareness of cancer symptoms.
2. support primary care improve access to diagnostic services, GP awareness of symptoms and referral pathways.
3. building capacity and quality of services in secondary care.

There are a number of challenges in reducing cancer morbidity, mortality and increasing survival. These include:

- Increasing screening coverage/uptake in the breast, bowel and cervical cancer screening programmes
- Tackling lifestyle-related cancer risk factors particularly smoking, obesity, physical inactivity and excessive alcohol consumption
- Addressing factors that contribute to late presentation for diagnosis and limited awareness of cancer symptoms amongst front line clinicians
- Implementing age extension for both bowel and breast screening programmes.

Recommendations

- Continued investment in early diagnosis through targeted community outreach work, GP training and increasing access to diagnostics e.g. flexible sigmoidoscopy and x-ray
- Develop targeted interventions for those who do not participate in screening programmes to increase screening uptake e.g. active follow up of DNAs through telephone calls, text messaging, letters offering second time appointments or recommending screening when eligible persons attend clinics³¹⁵
- Address cancer risk factors such as smoking, obesity, physical inactivity and excessive alcohol consumption e.g. by ensuring GPs and hospital clinicians have easy access to stop smoking services, weight management programme to refer patients; provide IBA training for frontline staff and encourage people to use leisure centres that provide a wide range of physical activities
- Implementing age extension for both bowel and breast screening programmes
- Implement systems to facilitate completeness in recording stage of diagnosis.

³¹⁵ Approaches to improving breast screening uptake: evidence and experience from Tower Hamlets; KW Eilbert, K Carroll, J Peach, S Khatoon, I Basnett and N McCulloch; British Journal of Cancer 101(S2), S64 – S67 (2009).

6.3 Cardiovascular disease (CVD)

Executive summary

CVD is the biggest killer in the London Borough of Waltham Forest and causes 24% of premature deaths (75 years and under). It is the main contributor for health inequalities between Waltham Forest and England. The borough has a higher burden of lifestyle risk factors for circulatory disease which includes smoking, physical inactivity, higher level of alcohol intake, unhealthy eating and obesity. Up to 19 in every 100 deaths from Coronary Heart Disease (CHD) are associated with smoking. Socio-economic deprivation is strongly associated with CVD prevalence and outcomes. There are significantly higher death rates in the most deprived wards compared to other parts of the borough. The premature (under 75 years) death rate for women in Waltham Forest is 56% higher than the national rate for CHD, and is fourth highest out of all London boroughs. As the local population ages, increasing demands will be made on health and social care needs. It is predicted that the highest increase in population over the next 20 years will be for men and women over the age of 50 with an estimated increase of 34% from 57,900 to 79,100 people.

Introduction

CVD, also called circulatory disease, describes a group of diseases which are caused by blockage or rupture of blood vessels. CVD embraces a range of conditions including atherosclerosis (blocked arteries), high blood pressure (hypertension), atrial fibrillation (AF), cerebro-vascular disease (stroke), aortic aneurysm (ballooning of the main artery) and peripheral vascular disease (PVD), which usually involves blockage of the blood supply to the legs³¹⁶. CVD is the number one killer and the main cause of premature deaths nationally and locally^{317, 318}. It is also the main contributor to the health inequality gap between Waltham Forest and England accounting for 34% of the life expectancy gap for men compared to 29% for women³¹⁹. Socio-economic deprivation is strongly associated with CVD prevalence and outcomes. Hypertension is one of the most important predictive risk factors in the development of CVD particularly CHD and stroke. Atrial Fibrillation and Type 2 Diabetes (T2DM) are also well known risk factors.

The two most important causes of CVD death are CHD and stroke. The precursors of these include angina (chest pain) and hypertension (high blood pressure). The main risk factors for CHD and stroke are high blood lipid levels, smoking, obesity, hypertension, diabetes, physical inactivity and high alcohol intake³²⁰. People aged over 65 years are most at risk, but strokes and heart attacks can affect people of any age, including children³²¹. Some ethnic groups such as South Asians and the Black African and Black Caribbean groups have a higher risk due to a genetic predisposition towards some of the key risk factors such as diabetes and hypertension.

³¹⁶ http://www.lho.org.uk/LHO_Topics/Health_Topics/Diseases/Cardiovascular.aspx (accessed 16th Sept 10).

³¹⁷ <http://www.nhs.uk/conditions/Cardiovascular-disease/Pages/Introduction.aspx>

³¹⁸ ONS mortality data (2008).

³¹⁹ http://www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesInterventionToolkit.aspx

³²⁰ J Mackay, G Mensah, Atlas of Heart Disease and Stroke. 2004 World Health Organization. Geneva.

³²¹ http://www.lho.org.uk/LHO_Topics/Health_Topics/Diseases/Cardiovascular.aspx (accessed 16th Sept 10).

Local picture

Demographic predictions

Increasing numbers of older people over the next decades will mean more complex health and social care needs. By 2031 42% of all people aged over 50 are projected to be of minority ethnic background. This has significant implications for the health and social care economy as these groups are at a greater risk of developing CVD compared to the general population.

These will lead to significant increase in the numbers of people with long-term limiting illnesses such as cardiovascular disease and diabetes. Data indicate that females survive longer and outnumber males from the age of 65 onwards in the local population. This has implications as older women are more at risk of poverty, given shorter employment histories and pension contributions.

Mortality rates

CVD all age mortality rates

All age CVD mortality rate in Waltham Forest (2009–11) was 170.6 per 100,000. This is significantly higher than England (155.6) and London (151.3). Male CVD mortality rates in Waltham Forest are significantly higher than female CVD mortality rates (217.7 and 135.7 respectively). The mortality rate in 2009–11 for persons who live in the most deprived areas of Waltham Forest was 230.7 per 100,000. This is 1.9 times greater than the mortality rate for persons who live in the least deprived areas of Waltham Forest. The variation observed in England and London are lower at 1.8 and 1.6 respectively.³²²

CVD related premature mortality in Waltham Forest

The Public Health Outcomes Framework has an objective of reducing the numbers of people dying prematurely, while reducing the gap between communities. One of the key indicators for this objective is early mortality from CVD.

CVD accounts for nearly one-fourth (23.7%) of all premature deaths in Waltham Forest which is not significantly different from England average. Similarly, the premature CVD death rate under 75 (directly standardised) in Waltham Forest is 58.0/100,000 not significantly different from England in 2009–11³²³. However, the equivalent figure for over 75 is significantly higher than England.

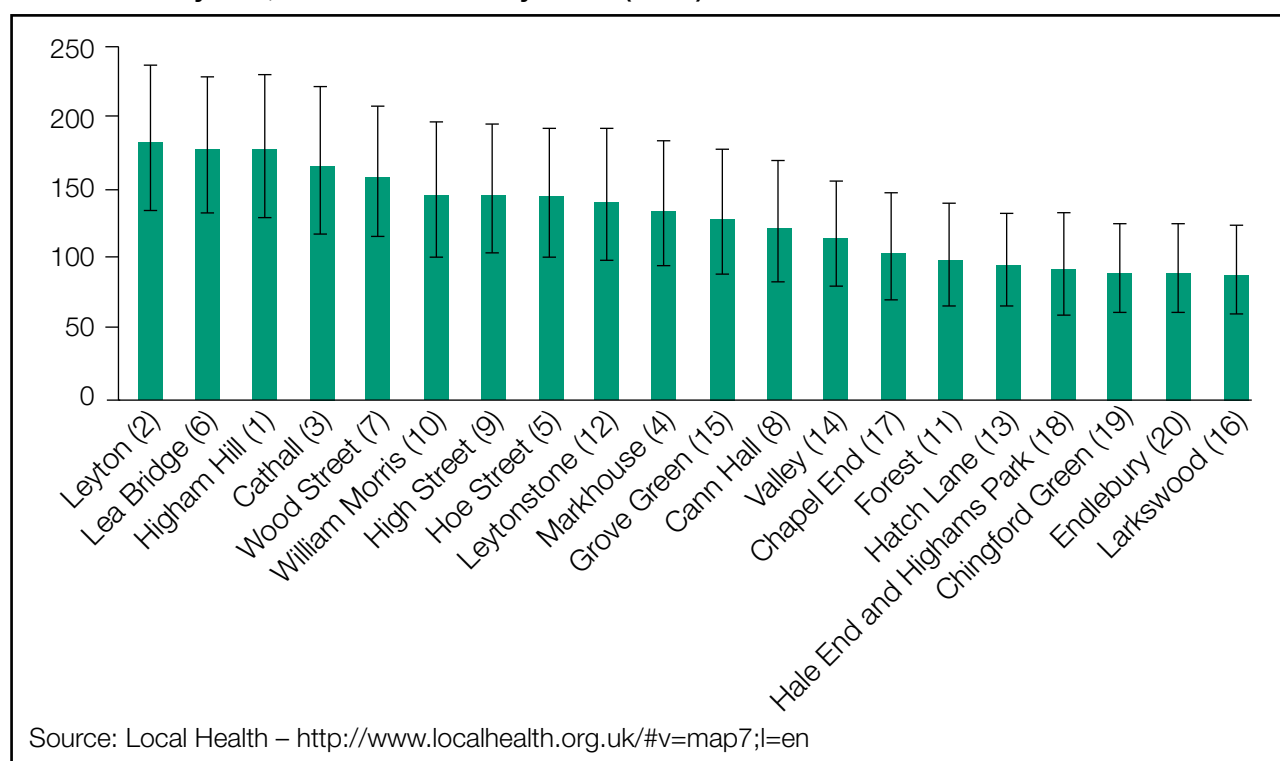
- In 2014 the early CVD mortality rate in Waltham Forest for persons under 75 years is predicted to be 62.8, which would be a 10 year decrease of 45.3% from 2004. The early CVD mortality rate for England is predicted to be 50.1, a ten year decrease of 44.2% and the London rate is predicted to be 51.2, a 10 year decrease of 46.6%. Local initiatives need to be in place to achieve these outcomes considering the groups who are most affected³²⁴
- Waltham Forest experienced 62.2% decline in under 75 CVD death rate from the baseline (1995–97). However, the inequality gap in mortality rates widened by 42% between 2001–09. Figure 6.11 below demonstrates the continuing gap between the rich and the poor in Waltham Forest where Most deprived wards, Leyton, Lea Bridge and Higham Hill experienced rates twice that of the least deprived wards including Larkswood and Endlebury.

³²² Cardiovascular disease health profile for Waltham Forest 2013; SEPHO.

³²³ Cardiovascular disease health profile for Waltham Forest 2013; SEPHO <http://www.sepho.org.uk/NationalCVD/atlas/atlas.html>

³²⁴ Cardiovascular disease health profile for Waltham Forest 2013; SEPHO.

Figure 6.11 Deaths from circulatory disease at ward level (deprivation ranking) in people under 75 years, Standard Mortality Ratio (SMR) 2006–10



CHD and stroke related premature death rate (directly age standardised) in Waltham Forest during 2009/2011 is 65.7/100,000 and not significantly different from the national rate.

However, mortality rate within 30 days of an ST elevated Myocardial Infarction (STEMI) is significantly higher than the national rate 15.1 vs 8.7/100,000 for 2009-2011 within LBWF.

Premature death rate for stroke in Waltham Forest is similar to the rate reported for England in 2011 (DSR per 100,000 Persons less than 75: England – 34.5; Waltham Forest – 36.3).³²⁵

Detection of CVD in Waltham Forest

Lower rate of detection of most CVDs including CHD, TIA/stroke, hypertension, atrial fibrillation (AF) and heart failure across the borough (compared to estimated number) in 2009/10 is an important public health concern:

- Only 34.5% % of CHD is detected and is significantly lower than the detection rate of 58.2% in England and 47.0% for London
- Only 34.1% of TIA/stroke are detected locally and is almost half of the rate of England and much lower than London (52.6%)
- Only 38.8% of hypertension is detected locally and compares to 46.0% for England and 41.5% for London.

Waltham Forest has a higher burden of main lifestyle risk factors for circulatory disease which includes smoking, physical inactivity, higher level of alcohol intake, unhealthy eating and obesity.

³²⁵ National Clinical Health Outcomes Database.

Specific CVD conditions

Coronary Heart Disease (CHD)

CHD is a condition where the arteries of the heart muscle become narrowed and blocked, starving it of oxygen. CHD manifests as angina and heart attack. CHD accounts for the majority of circulatory diseases and is the single most common cause of premature death in the UK³²⁶.

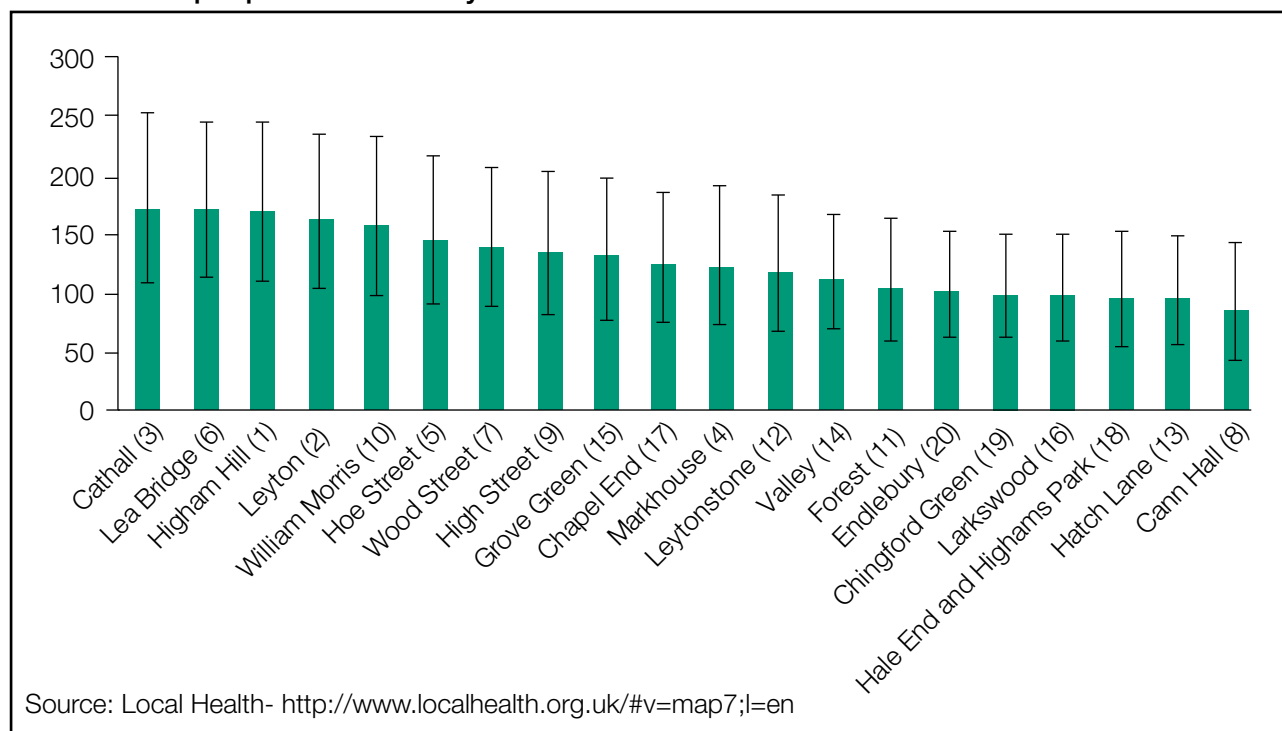
Chest pain-related service use

In the UK, up to 1% of visits to a GP are because of chest pain. Approximately 5% of visits to the emergency department and up to 40% of emergency hospital admissions are because of chest pain. Conditions causing chest pain, such as acute coronary syndrome (myocardial infarction or unstable angina) or stable angina, have a potentially poor prognosis. Fast and accurate diagnosis of chest pain or discomfort caused by these conditions is essential so that treatment can be offered quickly. Quick recognition of the symptoms followed by calling 999 means that heart attack survivors can be treated faster, which is an imperative as that results in better outcomes. This means that heart attack survivors are likely to return to their normal day-to-day activities.

Public Health England (PHE) is working to raise awareness of the signs and symptoms of heart disease to educate the public by running campaigns such as Act FAST and trialling new campaigns³²⁷. This is timely as the qualitative research undertaken locally showed that most people were not aware of other signs and symptoms of heart attack other than chest pain.

CHD related premature death rates in Waltham Forest

Figure 6.12 Standard mortality ratio (SMR) 2006–10 CHD at ward level (deprivation ranking) in people less than 75 years



Similar to the gap in mortality between most deprived Cathall, Lea Bridge and Higham Hill experienced Around 70% higher rates compared to less deprived Hale End and Highams Park (Figure 6.12 above).

³²⁶ UK coronary heart disease statistics 2009-10: G30UK stats factsheet 0210 www.bhf.org.uk/plugins/PublicationsSearchResults/

³²⁷ Cardiovascular Disease Outcomes Strategy (DH) March 2013.

Local picture of CHD

The incidence of CHD is higher amongst men, the elderly and in the more deprived areas. Based on GP registers, there are 6114 CHD patients with a prevalence of 2.1% (QOF 2011/12).³²⁸

Table 6.11 Actual prevalence (QOF 11/12) of CHD in NHS Waltham Forest by localities

Waltham Forest	Number	%
Chingford	1,790	2.8%
Leyton Leytonstone	1,981	1.8%
Walthamstow	2,343	2.0%
Waltham Forest	6,114	2.1%

Source: HSCIC Health and Social Care Information Centre, QOF 2011/12.

There is a wide variation in the prevalence across practices, ranging from 0.3% to 4.7%.³²⁹ Detected prevalence across the borough (3.4%). Patients with CHD who are not diagnosed are more likely to suffer disease progression and premature death.

CHD related premature death rate in Waltham Forest is similar to the national average for both males and females (67.47 vs 26.26, 2008–10). There has been a decline in the premature deaths due to CHD from 1993 to 2010³³⁰ in both sexes. The rate of decline is however slower than London and national rates.

CHD mortality is not distributed evenly across Waltham Forest where the more deprived wards experience higher mortality. CHD premature mortality (171.6 per 100,000) in Cathall and Lea Bridge wards were the highest across the borough and significantly higher than the national rate. Compared to less deprived Hale End and Highams Park (96.8) and Hatch Lane (96.8) Wards, the rate reported for both Cathall and Higham Hill were around 75% higher.

Mortality for Acute Myocardial Infarction (AMI)

In 2008–10, the premature death rate significantly higher locally compared to the national rate (24.76 and 15.2 per 100,000 population respectively).³³¹

QOF performance 2011/12 provisional

PCT targets have been achieved for all the CHD related QOF indicators. However, there is wide variation across practices. Higher exception rates reported by some practices also influence clinical outcomes for some groups of patients. The outlier practices need to be supported to improve quality of care and reduce inequalities. Work is already underway through the Waltham Forest CVD Board to visit and support practices to reduce variation.

Local progress

In the UK, up to 1% of visits to a GP are because of chest pain (Nilsson *et al.* 2003). Approximately 5% of visits to the emergency department and up to 40% of emergency hospital admissions are because of chest pain.

A rapid access chest pain clinic is run at Whipps Cross University Hospital where GPs could refer patients directly to avoid the delay in treatment. Development of evidence-based user friendly referral protocols and increased awareness among GPs combined with public awareness of symptoms of heart disease are likely to improve efficiency and outcomes.

³²⁸ HSCIC – Health and Social Care Information Centre, QOF data 2011/12.

³²⁹ HSCIC – Health and Social Care Information Centre, QOF data 2011/12.

³³⁰ National Clinical Health Outcomes Database.

³³¹ *Ibid.*

Emergency admissions rate for CHD

The emergency (or non-elective) admission rate for CHD in Waltham Forest has decreased by 19.7% between 2004/05 and 2011/12. This rate of decline is lower compared to London and national rates³³². Similar to previous years, the rates for males and females in 2011/12 were 313.1 versus 146.5 per 100,000, which was significantly higher compared to the national rate of 279.9 versus 124.6.³³³ Cathall had the highest emergency admissions for CHD and MI across all wards in the borough in 2011. High percentage of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions³³⁴. This indicates the need for timely diagnosis of undetected patients in the community.

Angiography and surgical procedures for CHD

Angiography is the radiographic visualization of the blood vessels after injection of a radiopaque substance. This is undertaken to identify blocked heart arteries before corrective surgery as part of management.

Heart conditions that are too complex to manage through lifestyle change and condition management require surgical procedures. The two main interventions (referred to as revascularisation) for treating heart disease are Coronary Artery Bypass Grafts (CABGs) and angioplasty, which is also known as a Percutaneous Coronary Intervention (PCI). Complex cases in which one or more arteries are blocked are commonly treated using CABG, rather than a PCI, which is a less invasive procedure. Both angiography rates revascularisation rates in Waltham Forest were significantly higher compared to national rate. Revascularisation rates for persons who live in the most deprived areas of Waltham Forest are 1.4 times greater than those who live in the least deprived areas. This indicates the relatively higher occurrence of cardiac events among more deprived communities incurring extra cost to the local health and social care economy.

Trend in non-elective angioplasty and CABG

Non-elective angioplasty rates in Waltham Forest have increased by 88% between 2004/05 and 2011/12. Elective procedure rates have decreased by 0.1%. In England and London non-elective procedure rates have increased by 74.8% and 19.1% respectively. Elective procedure rates have decreased by 15.7% and 18.4% respectively.

CABG procedure rates in Waltham Forest have increased by 21.8% between 2004/05 and 2011/12. In England and London CABG procedure rates have decreased by 25.4% and 18.1% respectively.

Cardiac rehabilitation

Waltham Forest residents benefit from a dynamic cardiac rehabilitation service that operates through Whipps Cross University Hospital and provides a range of specialist exercise programmes. Patients are contacted within 48 hours of receiving the referral from the specialist tertiary centres. All clients are invited to the Phase 3 programme within 6 weeks post surgery, 4 weeks after a Myocardial Infarction, and 2 weeks after a PCI (angioplasty).

Patients with acute coronary syndrome, myocardial infarction and CABG are the most common types of patients participating in the programme. Approximately 50 patients receive home-based programmes. The service currently accepts patients with varying levels of heart failure. Numbers are limited as this client group require greater vigilance during exercise sessions. The service would need to expand its staffing and resources to enable the greater vigilance required of this group of patients with heart failure. Limited accessibility to heart failure is a national issue as well and is highlighted in the CVD Outcome Strategy³³⁵ as an important unmet need that needs to be addressed³³⁶.

³³² Cardiovascular disease health profile for Waltham Forest 2013; SEPHO.

³³³ *Ibid.*

³³⁴ *Ibid.*

³³⁵ Cardiovascular Disease Outcomes Strategy (DH) March 2013.

³³⁶ Stroke Risk Factors: American Heart Association, <http://www.startchallenge.org/presenter.jhtml?identifier=4716>

Evidence-based interventions

Waltham Forest CVD Board developed and agreed the local care pathway for chest pain to align with the NICE clinical guideline CG95 on Chest pain of recent onset on assessment and management of patients with Chest Pain of recent onset published in October 2011. The current outpatient referrals on chest pain are being benchmarked across practices to reduce variation and ensure adherence to pathway when making referrals to acute care:

- Studies have shown that if lifestyle targets for primary prevention of CHD are met, approximately 75,000 CHD events would be prevented per year nationally, with the greatest gain coming from reduced blood pressure levels³³⁷. Therefore, reducing hypertension (elevated blood pressure) is a prime prevention target for reducing CHD.

Stroke

A stroke occurs when the blood supply to a part of the brain is suddenly cut off. This may be due to a blockage in a blood vessel or when a blood vessel in the brain bursts, spilling blood into the spaces surrounding the brain cells. This can leave lasting damage, affecting mobility, cognition, sight or communication³³⁸.

A transient ischaemic attack (TIA) is a minor stroke lasting less than 24 hours, which is often an important warning sign of a more serious stroke, heart attack or other vascular event. The risk of stroke in the first 24 hours after TIA is higher than the risk of a heart attack after an episode of chest pain.³³⁹

The risk of stroke increases with age but the most important risk factor amenable to intervention is hypertension. Other important risk factors include a previous TIA, atrial fibrillation, diabetes, smoking, obesity, poor diet (including high salt intake) and high alcohol intake.³⁴⁰

People aged over 65 years are those most at risk. There is also a higher risk of stroke for people in the black African and black Caribbean ethnic groups due to a genetic predisposition towards some of the key risk factors such as hypertension and diabetes. Stroke rates for this group are twice that for whites. On average black people experience their first stroke at 61 years, while White people about twelve years later at aged 73.³⁴¹

Stroke: the local picture

In Waltham Forest there are estimated to be 370 strokes per year^{342, 343}. In 2011/12, the prevalence for stroke/TIA in Waltham Forest was 0.91%³⁴⁴ compared to the national prevalence of 1.74%. The observed prevalence for stroke in Waltham Forest is 34.1% of the estimated prevalence. This compares to 68.4% for England and 52.6% for London³⁴⁵.

³³⁷ Gemmell *et al.*, Potential population impact of the UK government strategy for reducing the burden of coronary heart disease in England: comparing primary and secondary prevention strategies BMJ Quality and Safety 2006.

³³⁸ Department of Health (2007), National Stroke Strategy (www.dh.gov.uk/stroke).

³³⁹ Department of Health. Improving Stroke Services: A guide for commissioners, Gateway reference 7418: December 2006.

³⁴⁰ Stroke Risk Factors: American Heart Association, <http://www.startchallenge.org/presenter.jhtml?identifier=4716>

³⁴¹ Balarajan R. Ethnic differences in mortality from of blood pressure with special reference to socioeconischaemic heart disease and cerebrovascular disease in imic status in a rural south Indian community. J Epide England and Wales. Br Med J 1991; 302: 560–564.

³⁴² ASSET for Commissioners Version 2.00b Sep 2009 (www.dh.gov.uk/stroke/ASSET).

³⁴³ Incidence and case fatality rates of stroke subtypes in a multiethnic population: the South London Stroke Register Wolfe *et al.* J Neurol Neurosurg Psychiatry 202;72:211-216. Cited in Ref.4).

³⁴⁴ National Clinical Health Outcomes Database.

³⁴⁵ Cardiovascular disease health profile for Waltham Forest 2013; SEPHO.

Table 6.12 Actual prevalence (QOF 2011/12) of TIA/stroke in NHS Waltham Forest by Clinical Commissioning Groups (CCGs)

CCG	Number	Prevalence
Chingford	874	1.4%
Leyton Leytonstone	795	0.7%
Walthamstow	997	0.8%
Waltham Forest	2,666	0.9%

Source – HSCIC, Health and Social Care Information Centre.

A high level of under detection of stroke/TIA is a significant unmet need. Given the high level of deprivation and a higher percentage of black Caribbean, black African and South Asians in Waltham Forest, one would expect a higher prevalence.

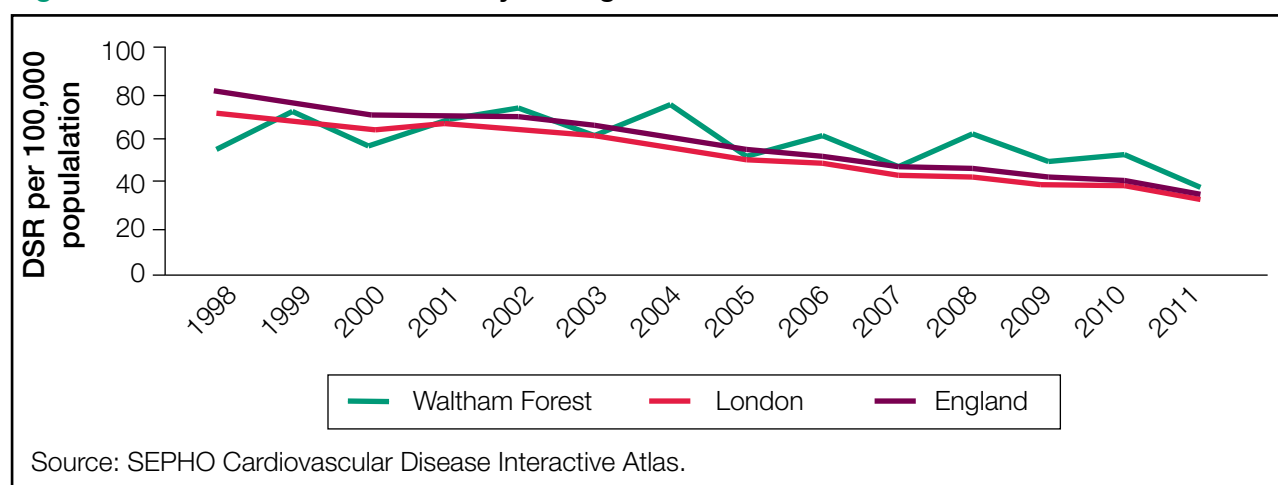
Gaps in knowledge of signs and symptoms of CVD

Focus groups with local communities that discussed CVD prevention in July 2011 highlighted that the high risk groups were not only unaware of the term TIA or mini-stroke but also have not heard of the signs or symptoms of TIA. However, they were well informed about the stroke signs and symptoms as a result of the FAST national campaign.

The estimated number of people living with moderate or severe disability following a stroke in 2010 is between 878 and 960³⁴⁶, which demonstrates long-term impacts on the quality of life for those affected and their families and also on the social care budget.

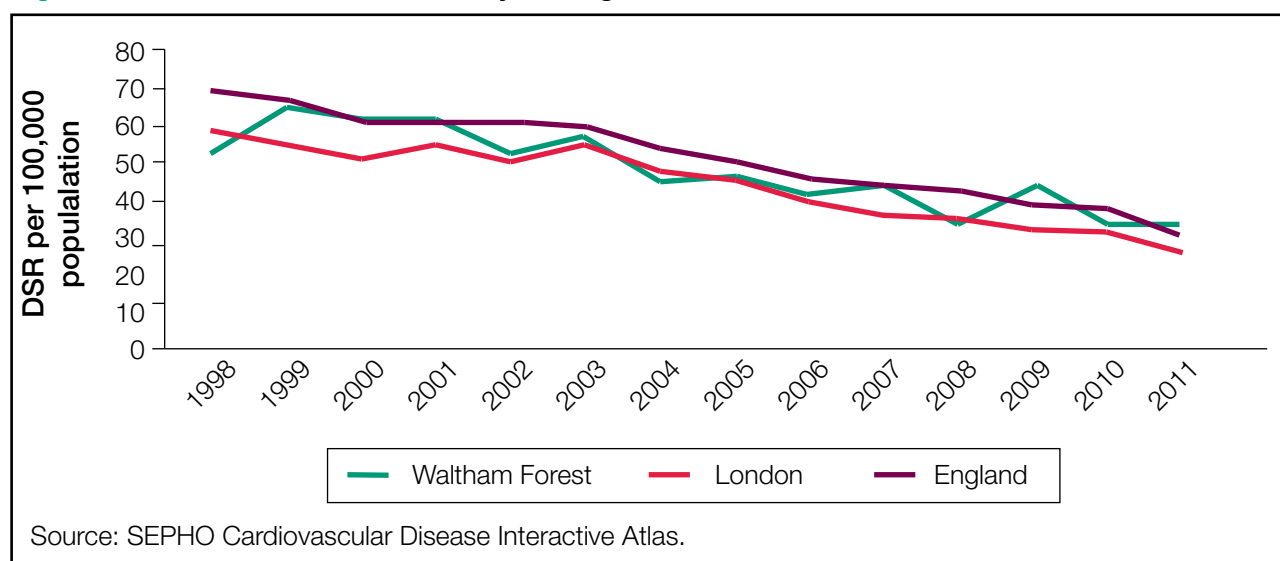
Stroke is the third biggest killer in England and the main cause of adult disability. A similar picture exists in Waltham Forest. In 2011, the indirectly standardised mortality rate (SMR) in persons under 75 years for was 36.3 per 100,000 population, which was similar to the rate reported for England (34.5).³⁴⁷ This is an improvement since 2007–09 reported rates.

Figures 6.13 and 6.14 show an overall downward trend in the mortality rates reported from 1993 to 2009 for England and London. Small numbers make it difficult to establish a trend in Waltham Forest, although it is generally going down.

Figure 6.13 Stroke-related mortality among men 1998–2011

³⁴⁶ Projecting Older People Population Information System and Projecting Adult Needs and Services Information System 2010 (based on the General Household Survey 2007).

³⁴⁷ Health and Social Care Information Centre (HSCIC).

Figure 6.14 Stroke-related mortality among women 1998–2011

Stroke of the optic nerve (eye stroke)

An eye stroke, or anterior ischemic optic neuropathy, is a dangerous condition in which blood flow either becomes blocked or reduced to the tissues of the front part of the optic nerve. An eye stroke can cause sudden loss of vision.

Causes of eye stroke

Eye stroke is caused by poor circulation in the blood vessels that supply the front portion of the optic nerve

Risk factors of eye stroke

Eye stroke is more common in middle-aged people and the elderly. Approximately 10% of patients that are affected with anterior ischemic optic neuropathy are under the age of 45. Cardiovascular disease raises your risk for developing the disease. Therefore adequate management of risk factors including high blood pressure, cholesterol and diabetes become key to prevention of eye stroke.

Primary Care Service provision related to stroke in Waltham Forest

The quality of care a patient receives in primary care has a direct impact on his/her risk of developing another stroke or cardiovascular event. Approximately 25% of people who recover from their first stroke will have another stroke within five years. The risk of having a second stroke is greatest within 30 days of the first one. A third of recurrent strokes take place within two years of the first stroke. Recurrent strokes are a major contributor to disability and death. The risk of severe functional restriction or death increases with each stroke recurrence³⁴⁸. Therefore secondary prevention interventions following a stroke event are crucial to prevent further events. A number of QOF indicators are in place to monitor the quality of these interventions delivered through primary care.

Emergency admissions for stroke

Stroke related emergency admissions rate in Waltham Forest in 2011 was 127.3 a reduction from 2009. However, this rate remains to be significantly higher than the figure of 89.5 observed nationally and in London (100.3 per 100,000). Effective interventions such as detection and management of high risk groups for CVD and proactive referral of suspected TIA to well equipped TIA clinic at Whipps Cross University Hospital for timely management need to be strengthened within the borough through the CVD board and multi-stakeholder partnership. These are significant partially met needs locally.

³⁴⁸ Stroke Education Ltd, <http://www.stroke-education.com/info/StrokeInfo.do>

Stroke Rehabilitation in Waltham Forest

Rehabilitation services following a stroke is an evidence-based intervention that improves the quality of life and reduces mortality due to stroke. Local stroke rehabilitation for many patients begins in secondary care on an inpatient basis. Waltham Forest stroke care specialists participate in a sector wide initiative to maintain and raise rehabilitation standards, ensuring that residents who have had a stroke receive inpatient rehabilitation that meets 17 quality of care indicators. The Waltham Forest service performs extremely well against these indicators assessed in 2011³⁴⁹, ensuring that patients will:

- Have access to a specialist inpatient rehabilitation unit with specialist multi-disciplinary teams
- Are assessed by all relevant members of the rehabilitation team including Occupational Therapists, Speech and Language Therapists, and receive psychological assessment
- Be involved in negotiating their rehabilitation goals and receive a copy of the goals within five days of admission
- Receive appropriate seating, posture and position advice within 24 hours of admission to the stroke unit
- Be allocated a named key or support worker within seven days of admission
- Offered a minimum of 45 minutes active therapy for a minimum five days a week if appropriate
- Have a joint care plan on discharge from hospital.

Stroke discharged to place of residence

In Waltham Forest, the percentage of stroke sufferers who were discharged from hospital to their usual residence was significantly lower (60.3%) than the national rate of 77.9%.

Follow up of patients with stroke after discharge

Following their discharge from the Whipps Cross University Hospital (WXUH) Stroke unit all patients are reviewed by the team at 6 weeks and at 6 months. The Stroke Service runs a multidisciplinary Spasticity service, wherein a Stroke Consultant Physician assesses the patient along with his Multi Disciplinary Team and optimises their spasticity management which includes Botulinum toxin injections into spastic muscle groups. Following their Botulinum toxin injections patients are reviewed by the treating therapist for further rehabilitation including consideration for splints and training for suitable set of exercises. This care pathway needs to be developed further to improve access to all eligible people.

Hyper Acute Stroke Unit (HASU) pathway for acute stroke in Waltham Forest

Residents in Waltham Forest benefit from the North East London HASU pathway available 24 hours a day, 7 days a week. HASU Referral pathway is available for urgent referral to The Royal London Hospital's HASU for acute stroke patients.

Early supported discharge

Early supported discharge (ESD) is proven to improve outcomes in stroke survivors. QIPP evidence supports the development of ESD services as recommended interventions to improve quality and cost-effectiveness. A community stroke rehabilitation team currently operates through the acute stroke unit at Whipps Cross University Hospital to support stroke survivors immediately following discharge from hospital. The Community Stroke Team service has been redeveloped and now provides full Early Supported Discharge and appropriate six month follow-up. This includes a Community Clinical Stroke Nurse Specialist and project management support. Long-term support is also required following initial home or community-based rehabilitation. Estimates for the people with long-term conditions due to stroke indicates a high level of need. This needs to be further developed and agreed pathways agreed with the specialist Stroke Team at WXUH.

³⁴⁹ North East London Rehab Quality Report, June 2011.

Table 6.13 Number of people aged 18–64 predicted to have a longstanding health condition caused by a stroke

	2012	2014	2016	2018	2020
Number (aged 18+) predicted to have stroke	408	422	435	445	455

Source: Projecting Adult Needs and Services and Projecting Older People Population Information Systems, 21 October 2013.

Support to stroke survivors and carers in the community

Life After Stroke Service – Stroke Service Stroke Navigator and Communication Plus Services provide a single point of access for stroke specialist advice, support, reviews and help to coordinate complex discharges. The service also provides 1:1 community-based support to Aphasia.

Supported activities to disabled, socially isolated and vulnerable adults/older people in Waltham Forest

The activities provided include sports, health and wellbeing activities, Independent living skill training, Arts and Crafts. In 2012/13 over 143 stroke survivors were supported in the community to improve their quality of life and personal dignity both the stroke navigator and communication plus support services.

Service is based at the North Resource Hub, however, activities take place at different location throughout the borough. Stroke Navigators also visit service users in their own home to offer personalised support.

Patients also benefit from the Waltham Forest Stroke Support Group at Longfield House, in Walthamstow. In addition older patients receive support from the LBWF including meals on wheel.

Evidence-based interventions

There is considerable scope for preventing strokes by addressing the key risk factors such as smoking, hypertension and excessive salt consumption.

The National Stroke Strategy sets out a framework of quality markers for raising the quality of stroke prevention, treatment; care and support over the next decades. This includes 11 key themes relating to prevention, early identification, acute care, rehabilitation and involvement of service users.

Most recent NICE Guidance (June 2013) offers evidence-based advice on the care of adults and young people aged 16 years and older who have had a stroke with continuing impairment, activity limitation or participation restriction. It makes emphasis on rehabilitation care, and to further improve outcomes³⁵⁰. There is ongoing work relating to redesign the spasticity pathway in order to further improve clinical and patient outcomes. This is likely to reduce the social care needs of people by preventing long-term disability and investment to undertake service changes need to be considered a priority.

Heart failure (HF)

Heart failure is a clinical syndrome caused by a reduction in the heart's ability to pump blood around the body. The prognosis is poor and survival rates are worse than, for example, breast and prostate cancer, with a high risk of sudden death. Up to 40% of patients die within the first year of diagnosis. Most cases of heart failure in the UK are due to CHD and about a third result from hypertensive heart disease.³⁵¹

³⁵⁰ Stroke rehabilitation, Long-term rehabilitation after stroke (June 2013) NICE clinical guideline 162.

³⁵¹ Pushing the boundaries, improving services for patients with heart failure, Commission for Healthcare Audit and Inspection 2007.

Heart failure (HF): the local picture

Table 6.14 Actual prevalence (QOF 2011/12) of HF in NHS Waltham Forest by locality

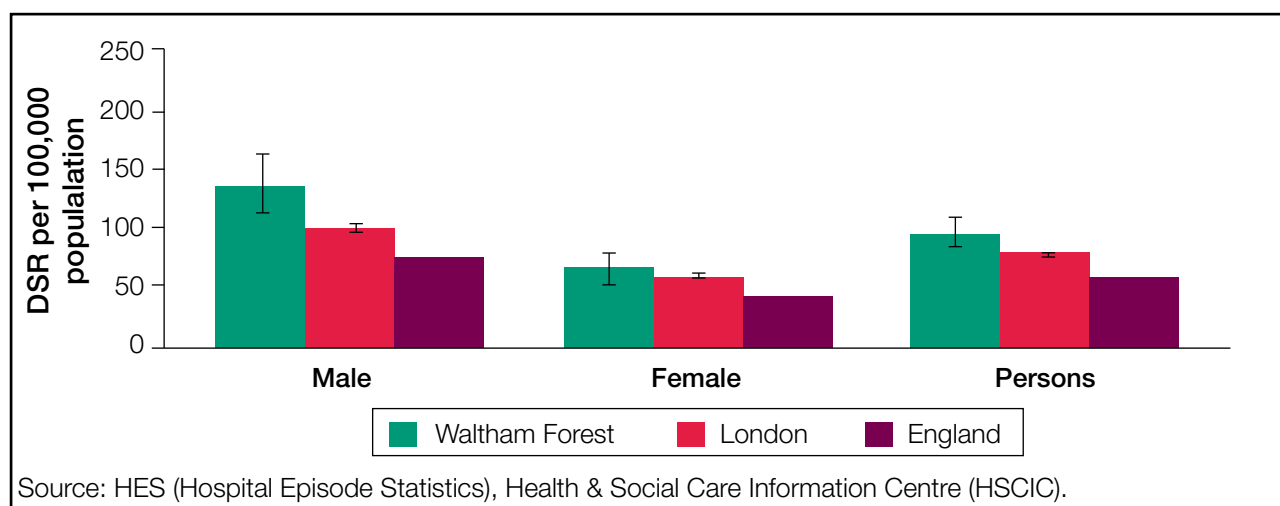
Locality	Number	Prevalence
Chingford	463	0.7%
Leyton Leytonstone	431	0.4%
Walthamstow	571	0.5%
Waltham Forest	1,465	0.5%

Data source: The Health and Social Care Information Centre QOF 2011/12.

Heart failure-related admissions

It is important to note that rates of emergency admissions related to heart failure in Waltham Forest were higher than the national rates from 2007/08. In 2011/12 the emergency admission rate for heart failure, all persons, in Waltham Forest was 98.4 per 100,000 (229 admissions). This is significantly higher than England (60.3 per 100,000) and London (80.3 per 100,000).

Figure 6.15 Heart failure emergency admission rates (DSRs), for all ages, 2011/12



Male heart failure emergency admission rates are significantly higher than female heart failure emergency admission rates. The emergency admission rate for heart failure in 2011/12 for persons who live in the most deprived areas of Waltham Forest was 2 times greater than the emergency admission rates for persons who live in the least deprived areas of Waltham Forest (66.2).

Evidence of effectiveness

NICE Guidance, Chronic heart failure³⁵² provides evidence-based guidance relating to heart failure, which is being implemented in Waltham Forest. In addition NICE Quality Standards on heart failure provide quality standards that needs to be achieved in delivering heart failure related care³⁵³. QS9 (June 2011). It is important to benchmark the current service to identify areas for improvement across the care pathway.

³⁵² Guidance Chronic heart failure (CG108 NICE).

³⁵³ Chronic heart failure. Quality Standards, QS9 (June 2011).

Progress made in heart failure service delivery since the previous JSNA

Significant achievements have been made across the heart failure care pathway in Waltham Forest to improve productivity, efficiency and effectiveness as a result of highlighting the need for change in the previous JSNAs (2010/11, 2011/12). These include:

- Establishment of the community-based heart failure specialist service in Waltham Forest
- Introducing Serum Natriuretic Peptides (Serum NP) for suspected heart failure patients to rule out other causes to align with recent NICE Guidance on HF.³⁵⁴

CVD-related risk factors

The main risk factors for CHD and circulatory disease are smoking and obesity and higher levels of disease are associated with areas of deprivation³⁵⁵. It is estimated that about 5% of deaths from CHD in males and 6% of deaths from CHD in females are due to obesity³⁵⁶. Up to 19 in every 100 deaths from CHD are associated with smoking³⁵⁷. Excessive alcohol consumption has been associated with an increased risk of CHD³⁵⁸. Hypertension is one of the most important predictive risk factors in the development of CHD³⁵⁹.

Hypertension

Hypertension is the most common cardiovascular condition nationally and locally. It is the single biggest risk factor for stroke. It also plays a significant role in heart attacks. It can be prevented and successfully treated but only if it is diagnosed and managed appropriately. The Health Survey for England found that Black Africans and Black Caribbean have above average prevalence of hypertension compared with the general population³⁶⁰.

Hypertension (high blood pressure (HBP)): the local picture

Modelled estimates show that prevalence of hypertension across Waltham Forest is about 28%³⁶¹.

Recorded prevalence of hypertension in Waltham Forest according to QOF 2011/12 is 10.9% with 32,173 registered patients in GP registers. The prevalence ranged from 2.1% to 19%.³⁶² Recorded prevalence in the borough reflects less than 50% of the modeled prevalence for Waltham Forest.

Hypertension is also linked to diabetes, which is more prevalent among ethnic minorities. However, good management can produce large reductions in Coronary Heart Disease as well as stroke. Additionally adequate control of hypertension is important to prevent heart failure, aortic aneurysm and peripheral vascular disease and chronic renal failure³⁶³ and visual impairment.

³⁵⁴ NICE Guidance on Heart Failure (2010).

³⁵⁵ Patel KCR, Bhopal The Epidemic of Coronary Heart Disease in South Asian Populations: Causes and Consequences: South Asian Health Foundation, ISBN: 0-9546712-0-1 <http://www.sahf.org.uk/uploads/docs/files/21.pdf>

³⁵⁶ National Heart Forum, 2009.

³⁵⁷ National Heart Forum, 2002.

³⁵⁸ Poikolainen, 1998.

³⁵⁹ (Wilson *et al.*, 1998).

³⁶⁰ Health Survey for England 2004.

³⁶¹ Estimates are based on two separate models derived from the Health Survey for England (HSE). These estimates have been produced for APHO by collaboration between the Yorkshire and Humber and Eastern Region Public Health Observatories and Doncaster PCT.

³⁶² HSCIC, Health and Social Care Information Centre, QOF, 2011/12.

³⁶³ Easing the pressure: tackling hypertension: Hypertension: public health burden (HDA 2005).

Uncontrolled hypertension (HBP) can lead to vision loss

- HBP can strain the vessels in the eyes and the optic nerve**
 High blood pressure can place a strain on the blood vessels in the eyes. HBP can cause the blood vessels to either narrow or bleed when they are subjected to too much blood pressure force. Also, the optic nerve may swell, reducing the ability to see well.
- Untreated HBP can cause permanent vision problems**
 Using an ophthalmoscope, a healthcare professional can look at the network of tiny capillaries on the retina to evaluate the condition of the blood vessels in the eyes. Managing blood pressure is the only way to treat hypertensive retinopathy. HBP damage is cumulative, so the longer it goes untreated, the higher the likelihood of permanent damage.
- HBP can cause a stroke which may lead to brain damage causing vision loss**
 High blood pressure can lead to stroke, which, in turn, can impair the optic nerve or damage the area of the brain responsible for processing images.
- Uncontrolled high blood pressure increases a person's stroke risk by four to six times. Over time, hypertension leads to atherosclerosis and hardening of the large arteries. This, in turn, can lead to blockage of small blood vessels in the brain. High blood pressure can also lead to weakening of the blood vessels in the brain, causing them to balloon and burst. The risk of stroke is directly related to how high the blood pressure is.

As mentioned previously, keeping hypertension to a level below 140mmHg systolic BP could prevent 34 strokes in Waltham Forest per annum.

Atrial fibrillation

Atrial fibrillation (AF) is the term used for a common type of irregular heartbeat and is an important risk factor in stroke, accounting for 14% of all strokes. The annual risk of stroke is five to six times greater in AF patients than in people with a normal heart rhythm. Early treatment of AF with Warfarin, an anticoagulant, reduces risk of stroke by 50 to 70%.

The prevalence of AF in Waltham Forest is 0.7% (same – no change) (2,128 patients in GP registers) with a range of 0.1% to 2.1%.³⁶⁴ This prevalence is lower than the national recorded prevalence resulting in AF going untreated in the population.

Table 6.15 Actual prevalence (QOF 2011/12) of AF in NHS Waltham Forest by locality

Locality	Number	Prevalence
Chingford	889	1.4%
Leyton Leytonstone	476	0.4%
Walthamstow	763	0.6%
Waltham Forest	2,128	0.7%

Source – HSCIC, Health and Social Care Information Centre.

³⁶⁴ HSCIC, Health and Social Care Information Centre, QOF, 2011/12.

Improved detection and management of patients with AF was a key factor in reducing the burden of stroke in the borough. Detection and treatment of AF in primary care is a published QIPP case study identified as a highly recommended intervention by their peer review process³⁶⁵. The programme recommends that opportunistic screening for pulse palpitations of patients over the age of 65, and subsequent treatment using anticoagulation supported by the GRASP tool. A proportion of Waltham Forest residents experience stroke and atrial fibrillation at a younger age, and GP recommend pulse checks to all adults over the age 40 to ensure optimal screening results.

Evidence-based interventions

In order to prevent AF related strokes, the recommended course of action is to initiate anticoagulation therapy. When this therapy is appropriately used and monitored, it is highly effective, lowering stroke risk by about two thirds. However, despite the clear benefits of Warfarin and the presence of guidelines for its use and management in stroke prevention, current data indicate that the management of AF is still suboptimal, with many of those receiving anticoagulation not consistently in the optimal therapeutic range.

It is evident from the recorded prevalence of AF that detection occurs at a lower rate than would be expected. The recorded prevalence is currently at 0.7% (same), compared to a recorded prevalence of 1.5% for England. Although the prevalence has remained the same over the past 3 years, the actual number of residents diagnosed with AF has increased from 1,782 in 2006/07 to 2,128 in 2011/12.³⁶⁶

Evidence of effectiveness

- The treatment of AF with Warfarin reduces risk of stroke by 50 to 70%
- The estimated total cost of maintaining one patient on Warfarin for one year, including monitoring, is £383
- The cost per stroke due to AF is estimated to be £44,000 in the first year after stroke occurrence³⁶⁷.

Current anti-coagulant management of AF is sub-optimal. NICE estimate that 46% of patients that should be on Warfarin are not on Warfarin in Waltham Forest:

- 630 is the estimated additional number requiring Warfarin according to NICE guidance
- 25 strokes would prevented if fully compliant with NICE guidance for prescribing Warfarin to patients with atrial fibrillation.

NHS Health Checks (NHSHCs)

Public Health England states that the NHSHC programme is a great opportunity to tackle avoidable deaths, disability and reduce health inequalities in England³⁶⁸ (PHE 2012). It is a mandated public health programme and the regulations state that LAs must achieve a 100% offer rate in their eligible populations after five years. Recently published National CVD outcome strategy 03/2013 sets out outcomes for people at risk of CVD and the programme will contribute to achieve the following outcome indicators of the NHS Outcome Framework and the public health outcome framework (PHOF).

- Life expectancy at 75*
- less than 75 mortality rate from cardiovascular disease (including CHD and stroke)*
- % of eligible offered Health Check (20% each year).

³⁶⁵ Atrial Fibrillation – detection and optimal therapy in primary care. NHS Stroke Improvement Programme, November 2009.

³⁶⁶ HSCIC, Health and Social Care Information Centre, QOF, 2011/12.

³⁶⁷ Guidance Chronic heart failure (CG108 NICE).

³⁶⁸ Public Health England report in 2012

- Take up rate of 75% by those offered**
- Demonstrate annual improvement in recorded diabetes**
- Smoking Cessation targets**.

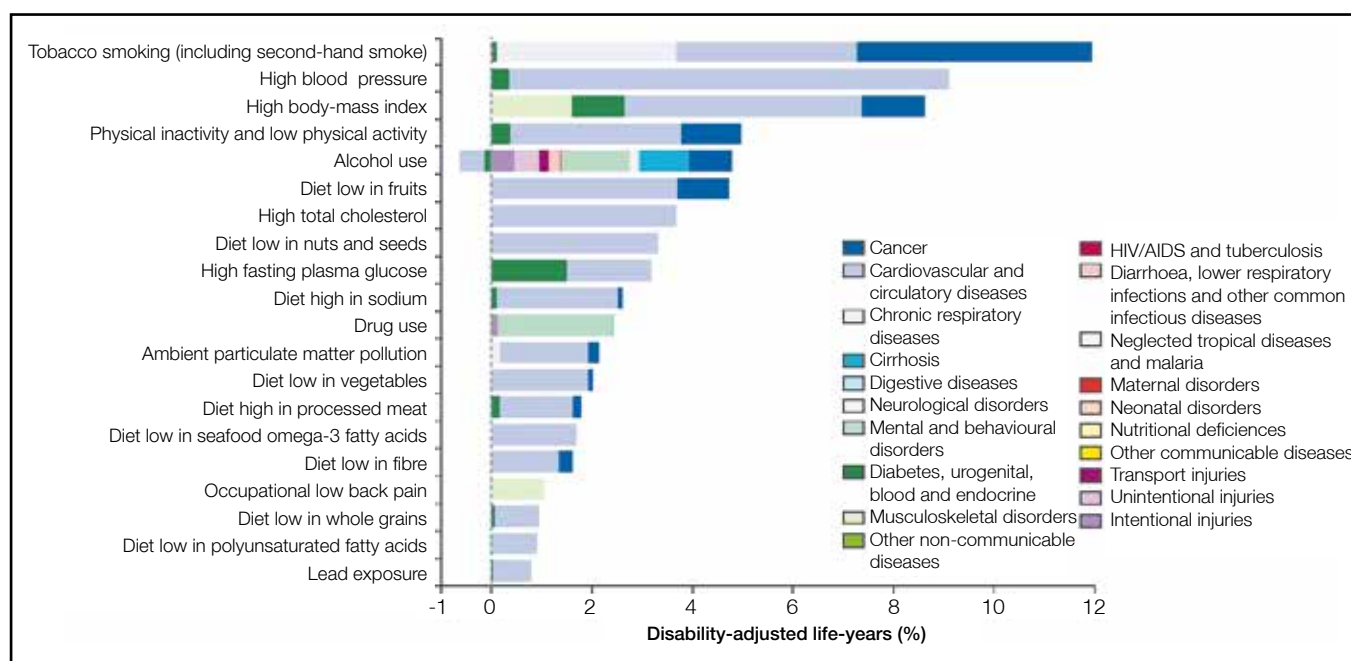
* NHS Outcome Framework.

** PHOF.

Systematically target top seven causes of preventable mortality (Figure 6.16)

High blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption.

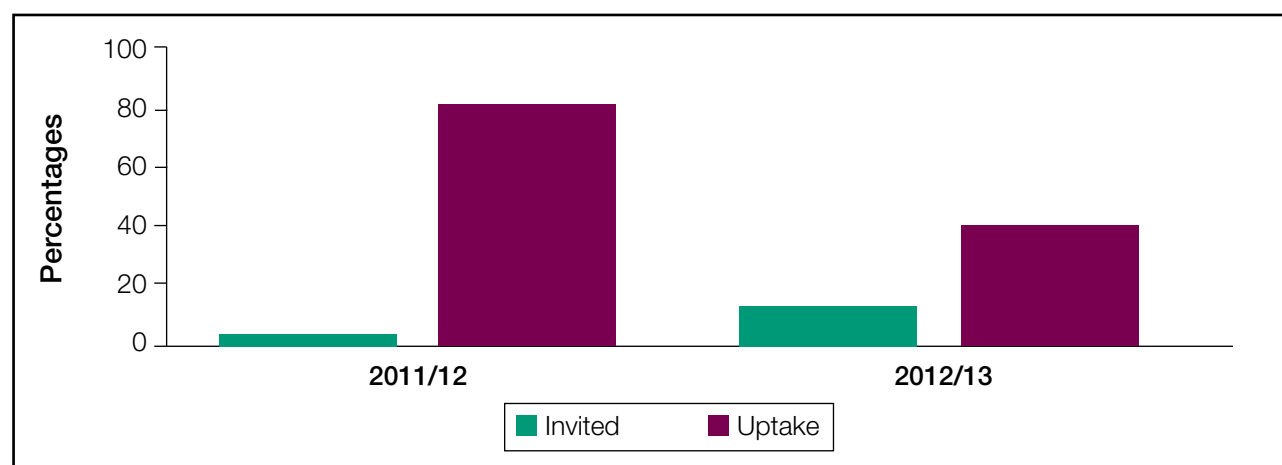
Figure 6.16 Burden of disease attributable to 20 leading risk factors for both sexes in 2010, expressed as a percentage of UK disability-adjusted life-years



In addition, NHC programme helps to prevent the onset of vascular disease and vascular dementia by supporting changes to and management of behavioural and physiological risk factors.

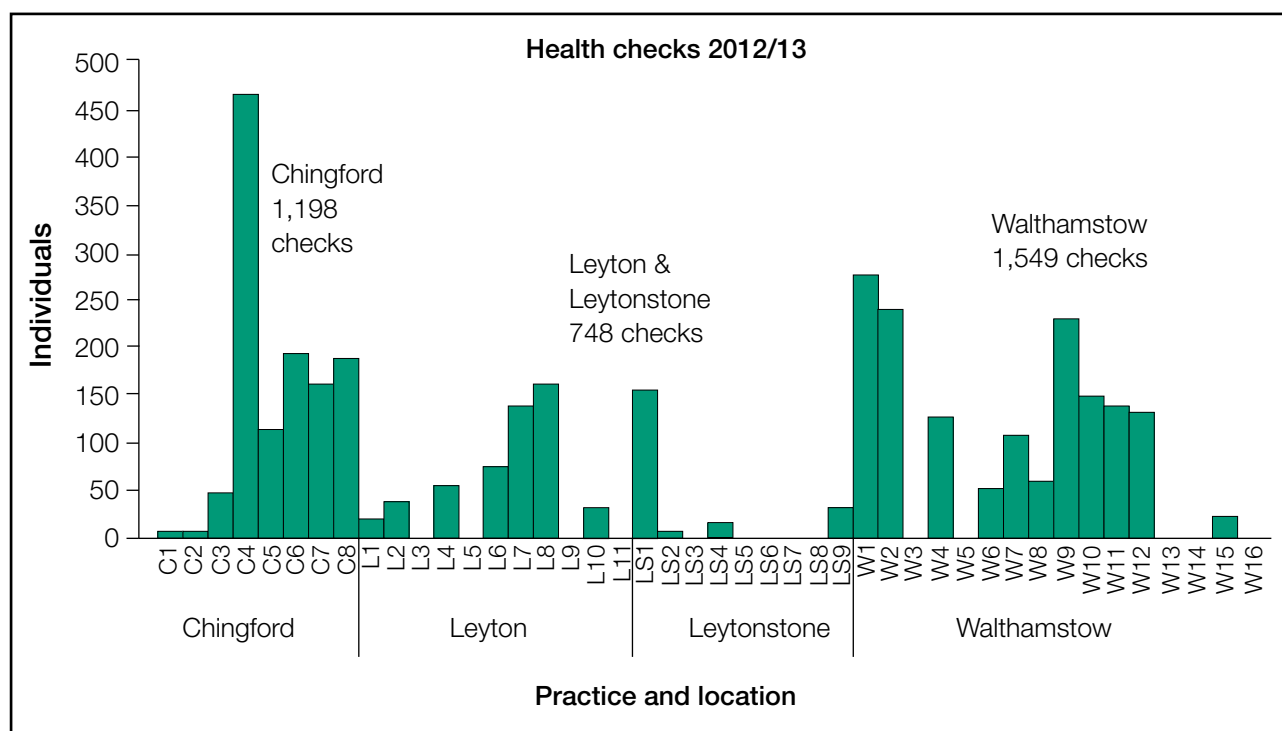
Local performance on NHSHC programme (uptake as a % of those invited)

Figure 6.17 NHS Health Check programme (uptake as a percentage of those invited)



As shown in Figure 6.16, Waltham Forest did not perform well on outcomes due to a number of gaps in the delivery leading to inequality of access (Figure 6.17). This is likely to further widen continuing inequalities unless appropriate measures are taken to deliver a robust programme with clinical leadership and consultation:

- Not establishing an agreed care pathway locally
- Lack of resources to support practices in smooth implementation of the service
- A number of practices did not sign up to the LES
- Targeted approach to communities living in wards with higher premature death rates and emergency admission rates
- Inconsistency in use of inviting people for checks inequity – not agreed initially
- No process to report or monitor lifestyles referrals and outcomes
- No process to ensure quality (audit/CG element).

Figure 6.18 NHSHC programme performance

Supporting people with cardiovascular disease – what is being done locally to address this issue?

Cardiovascular disease (CVD) is the main cause of long-term disability in adults. The needs and support required varies depending on the needs of the individual. The London Borough of Waltham Forest works with local groups to provide a range of support for people living with CVD and for those who provide their daily care needs, paid and unpaid. POHWER is an advocacy organisation that provides information and advice to help people plan, choose and manage their care needs. Age UK, the Stroke Association and range of local community groups offer services to help people live at home, facilitate rehabilitation and support independence. There are financial planning support services available for people who have been assessed as needing help and decide to pay for their own care and services or have Personal Budgets available to them. These services provide advice and information on how to plan and spend money to achieve the outcomes residents with care needs require.

The local authority has prioritised the needs of people who care for others through the development of single access resource hubs. The hubs will be open in four areas support carers to access independent information, advice and advocacy support, provide emotional support and training to enhance the general wellbeing and independence of carers. Many of the services mentioned above are accessible through the hubs.

Recommendations

Data

- Use Health Analytics to obtain timely data to plan and monitor equity and quality of NHS Health Checks delivery, Atrial Fibrillation, heart failure and TIA/stroke care pathways
- Undertake an in-depth analysis of exception reporting related to CVD to plan appropriate interventions
- Undertake an audit of patients readmitted for cardiac surgical interventions to assess the management of underlying conditions and risk factors
- Establish a process to combine health and social care data for effective and efficient use of resources to deliver specific services.

Quality

- Develop a joint cardiovascular strategy to align with national and London policy/guidance underpinned by local needs and service gaps
- Implement NHS Health Checks with particular emphasis on areas of high mortality and deprivation as a priority with a 6months review to assess the model of service delivery
- Improve AF care pathway to promote proactive case finding, identify and appropriately manage high risk patients to improve prescribing of anticoagulants adhering to NICE guidance
- Proactive detection of undiagnosed patients with high blood pressure and improve the percentage of people with controlled blood pressure using targeted outreach work-based on actual/estimated ratio in primary care
- Reduce variation in quality of primary care in CVD by supporting selected practices through benchmarking practices and continuing to support selected practices through practice visits
- Develop a robust plan for education and training of primary care clinicians (sharing best practice that exists within the borough) on a regular basis on identified priorities
- Invest in the development of stroke specific Early Supported Discharge service that incorporates all NICE recommendations, ONEL stroke quality standards and includes the provision of 6 month post discharge review in appropriate settings
- Develop and agree a local model for improving end of life care pathway for heart failure in partnership with key stakeholders.

Services

- Implement and monitor the community-based specialist HF service combined with appropriate publicity and agreed process of monitoring of referrals to maximise effectiveness of this service
- Tailor long-term support services that assist stroke survivors and their carers to improve confidence, mobility and independence
- Provide support and contribute to the ONEL QIPP integrated care model related to CVD to reduce high impact users i.e. Heart Failure and CHD
- Invest in targeted innovative culturally appropriate social marketing to raise public awareness of early signs/symptoms of heart disease, TIA/stroke, AF and hypertension to encourage seeking early treatment
- Use the findings of the qualitative research undertaken among high risk communities in July 2011 on CVD prevention to inform the above recommendation
- Continue to designate smoking as a priority particularly aimed at deprived communities and those with higher smoking rates
- Work with relevant leads to develop a co-ordinated programme of personalised advice and support services to encourage quit smoking, promote physical activity and sensible drinking and reducing overweight/obesity based on assessed needs.

Priorities for the next five years: gaps and challenges

1. Reduce the continuing inequalities and increasing demand related to CHD and stroke through:
 - provision of a combination of proactive, innovative and culturally appropriate social marketing to address CVD risk factors particularly smoking, hypertension, physical inactivity and high cholesterol targeting wards with higher mortality and admission rates.
2. Address under-detection of CHD, TIA/stroke, hypertension, atrial fibrillation and heart failure which is an unmet need across GP practices through a proactive targeted approach through clinical leadership and community engagement.
3. Ensure NHS Health Checks are implemented with a robust call/recall function and an additional outreach initiative to reduce inequity in service access targeting wards with highest needs.
4. Reduce variation in quality of care for CVD reflected through QOF performance and high exception reporting in certain practices warrants further analysis of exception reporting and appropriate interventions.
5. Redesign the stroke rehabilitation pathway with emphasis on improving timely provision of care for people with spasticity following stroke.
6. Mainstream the community-based specialist heart failure service to sustain improved quality of care and outcomes.
8. Address wider determinants related to CVD to reduce the deprivation related inequalities.

Challenges

- High level of deprivation and cultural diversity remain as big challenges in providing equity in access to services in primary, secondary and community care. Language appears to be a barrier in communicating with health care professionals particularly among unregistered recent migrants
- Higher level of CVD risk factors (smoking, obesity, physical inactivity) and poor health literacy relating to CVD
- High level of exception reporting in primary care relating to CVD.

6.4 Learning disabilities

Executive summary

People with learning disabilities are among the most vulnerable and socially excluded people in Waltham Forest. They are more likely to:

- have poorer physical and mental health
- have difficulties in accessing health care
- be at risk of abuse and suffer discrimination
- need support to access housing and employment, as more likely to be unemployed compared to the general population
- be at a greater risk of ending up in prison.

There are an estimated 4,514 people with learning disabilities resident in Waltham Forest. Of these, 1,028 have moderate/severe learning disabilities and 78 have challenging behaviours. Also, 741 are currently receiving services from the Community Learning Disability Team.

There is a forecast of an increase in the prevalence of people with learning disabilities over the next 10 to 15 years, with the highest increase being among those with the most severe learning disabilities and additional complex needs. In addition, there is a forecast of an increase in the number of young people with learning disabilities reaching adulthood that will require support from health and social care services between now and 2020.

Data recording in both health and social care are not consistent and this makes it difficult to estimate the number of people with learning disabilities in Waltham Forest who have a specific diagnosis or type of learning disability (i.e. complex needs, including behavioral issues, mental health condition, dual diagnosis and complex physical needs) to enable commissioners to map future needs and plan accordingly.

Health and Social Care commissioners require robust data in order to develop a more holistic knowledge and understanding of the current and the future trends of the learning disability population in Waltham Forest.

The following are the strategic priorities for the Learning Disabilities Service:

- Personalization – Access to good information, advocacy and person centered planning, choice and control to access to self-directed support, and promoting the use of community-based resources
- Supporting Carers to continue in their caring role and to be engaged in development of services
- Ensuring that transition into adult life is smooth and person centered and to improve on the good practice which already exists. A multi-disciplinary transition team was established this year which is working with young people from the age of 14 years, this help to improve the transition pathway for young people

- Protecting people from harm ensuring that the process for safeguarding adults at risk is robust and the needs of people with learning disabilities is recognized with regards to Community Safety. An action plan has been developed in relationship to the Winterbourne View recommendations
- People living in settled accommodation in the community
- Supporting people to gain meaningful employment
- Good Health and access to health services. A joint report by the learning disability service and Public Health has been written; this considers the findings from The Confidential Enquiry in to the Premature Deaths of People with a Learning Disability and makes recommendations for improving health services for people with learning disabilities
- Reducing the number of out of borough placements and increasing the opportunity of accessing housing and support locally.

Recommendations

- To commission services in line with the expected increase in the prevalence of people with learning disabilities over the next 10-15 years
- To work closer with GPs to improve health outcomes for people with learning disability and continue to commission the Learning Disabilities Direct Enhanced Service (DES) to ensure that practices are offering high-quality annual health checks to those who are eligible. To also consider alternative methods of delivering health checks to people with learning disabilities who are registered at practices but have not signed up to the DES. The Community Learning Disability team offer support to GP practices, this is by supporting individuals to access services and by advising GP and associated health staff to make reasonable adjustment to improve health access for people with a learning disability, this work will continue
- Complete and implement the Autism and Learning Disability Strategies
- To complete the Health Self Assessment and have a clear action plan to take forward which ensures that access to health services improves for people with a learning disability
- To complete Autism SAF and develop and action plan
- To ensure that preventive services are available to people with a learning disability
- To continue to stimulate the local market to ensure appropriate/relevant provisions is available locally to meet the needs of people with challenging behavior and autism. Also, including the need for autism awareness training to be covered in the contractual arrangements for commissioned services
- Care pathways including diagnostic pathway for people with autism spectrum disorder to be integrated in service planning. North East London Mental Health Trust are developing an autism care path and this will be implemented across the partner agencies
- To understand the demand for and the costs of specialist services to ensure that service provision is delivering value for money
- Ensure that robust reviews and ongoing monitoring of both health and social care 'Out of Borough Placements' with specific focus on people with challenging behaviour; people in high-cost placement; people with mental health needs; and people with complex needs and people in health funded inpatient units,(as recommended by the Winterbourne View report)
- To work with wider voluntary sector providers to create volunteering opportunities and support people with learning disabilities to get into employment
- To increase the opportunities for people with a learning disability to access community-based resources

- Ensure that joint health and social care commissioning strategies and protocols for young people reflects the demographic information relating to the increase needs for services for people with complex needs
- The population of people with a Learning Disabilities and dementia is increasing; dementia strategies and care pathways need to reflect the increase demand on services for people with an LD
- To understand the distinctive needs of people with profound and multiple learning disabilities and ensure that appropriate health and social care service provision is in place locally to meet needs whilst delivering value for money
- Review community care for people with learning disabilities to identify ways of reducing rate of emergency admission in this group and provide a service which promotes a preventative and enabling model
- Ensure that Waltham Forest keeps abreast of any other developments as a result of the recommendations made by the Confidential Enquiry, for example the resuscitation guidelines.

What are learning disabilities?

A 'learning disability includes the presence of a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning); which started before adulthood with lasting effect on development'. This definition includes people with autism who also have learning disabilities, but not those with a higher level of autistic spectrum disorder who may be of an average or even above average intelligence, such as some people with Asperger's syndrome (Valuing People (2001).

This definition encompasses people with a broad range of disabilities. The presence of a low intelligent quotient, for example an IQ below 70, is not, or in itself a sufficient reason for deciding whether an individual should be provided with additional health and social care support.

The World Health Organisation also defines learning disabilities as 'a state of arrested or incomplete development of mind'. Somebody with a learning disability is also said to have 'significant impairment of intellectual functioning'. The presence of a low intelligence quotient [IQ] below 70 is one of several indicators of learning disability, and 'significant impairment of adaptive/social functioning'. This means that the person will have difficulties understanding, learning and remembering new things, and in generalising any learning to new situations. The term learning disability does not include all those who have a 'learning difficulty' which is more broadly defined in education legislation.

People with learning disability have a range of development needs. Learning disability affects the way a person learns and copes with new things in any area of life. It means it is harder for the person to learn, understand and communicate when compared to other people and it may also mean the individual is more vulnerable to exploitation and abuse. In addition, there may be other needs because of physical disabilities and or sensory impairments.

Due to the wide range of possible needs, people can be assessed with mild, moderate, severe and profound/complex disabilities. The difference between these assessments is the level of help that they need with their daily living.

What is the local picture?

Prevalence of learning disabilities

It is difficult to estimate the number of people with learning disabilities in England. Statistics that are collected tend to relate to the numbers of adults receiving services Emerson and Hatton estimates 2% of the total population have learning disabilities. Less than 0.5% of these are likely to be known to local health and social services. But these numbers vary with age³⁶⁹. In Waltham Forest it is estimated there are 4,514 people with learning disabilities but only 1,056 are known to health and social care services³⁷⁰.

Increasing prevalence

Factors that are likely to lead to an increase in the prevalence rates for adults with learning disabilities over the next two decades are:

- An increase in proportion of younger adults from South Asian communities (as evidence suggests a two to three-fold increase in severe learning disability)
- Increase in the survival rates among young people with severe and complex disabilities
- Reduction in the mortality rate among older adults with learning disabilities.

The Department of Health website – Projecting Adults Needs and Service Information (PANSI) provides an estimate of the number of people in Waltham Forest affected by different level of learning disabilities www.pansi.org.uk.

Table 6.16 Estimated number of people affected by different levels of learning disabilities

Age 18 to 85	2012	2013	2014	2015	2016
LD Waltham Forest baseline	4,813	4,861	4,915	4,961	5,012
Severe learning disability (18-64)	259	262	265	268	271
Moderate/severe learning disability	1,028	1,040	1,054	1,067	1,081
Challenging behaviour (18-64)	78	79	80	81	82
Autism spectrum (18-64)	1,761	1,784	1,809	1,833	1,853
Down's syndrome (18-64)	109	110	111	112	113
People with learning disability living with a parent (18-64)	390	395	399	403	407

Source: PANSI 2012.

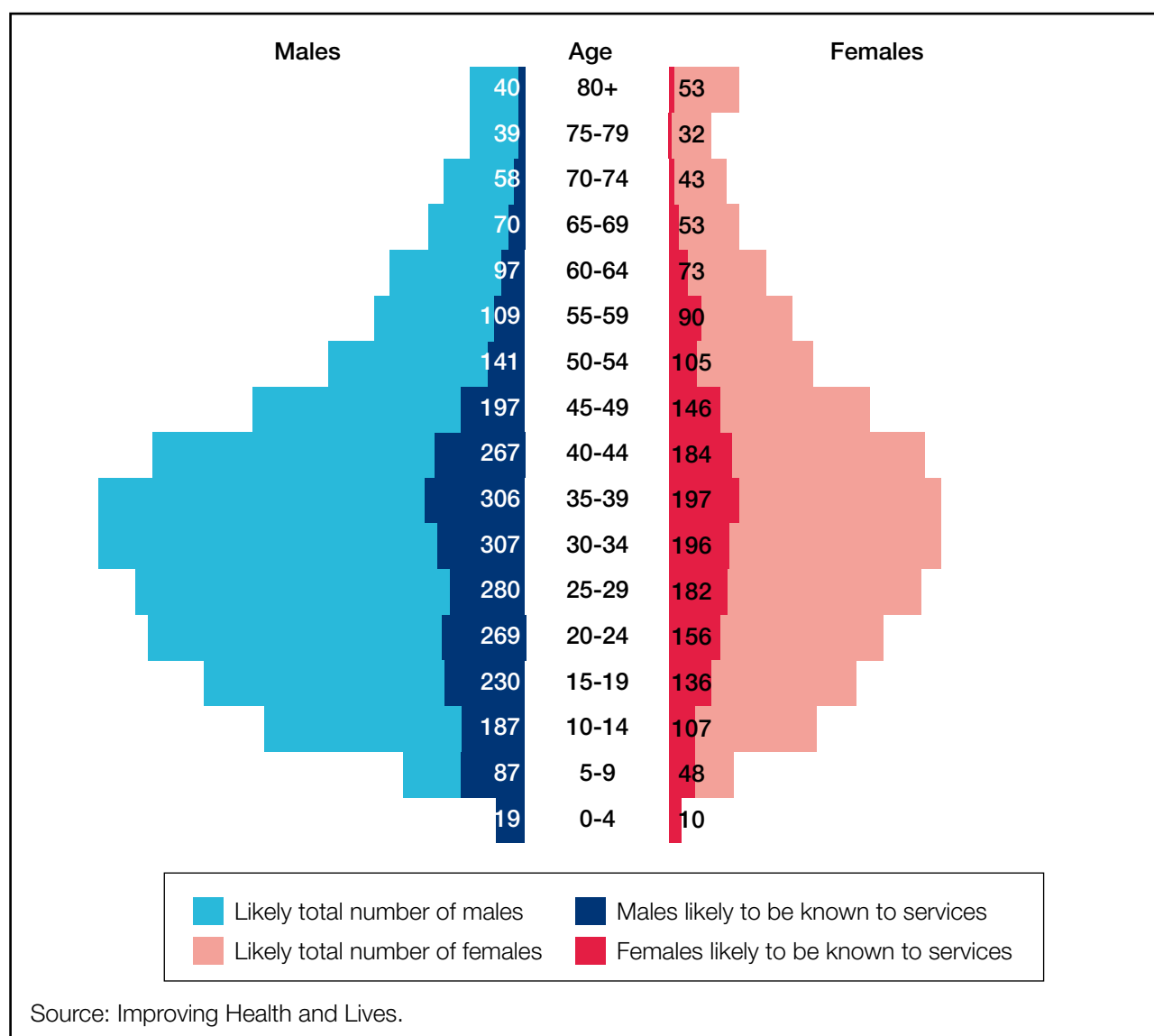
Age profile

The largest number of people with learning disabilities (PLD) in Waltham Forest is between the ages of 25 and 54 (See Figure 6.19 below), indicating a future increase of older people with learning disabilities. An increase in age related illness in the next 10 to 20 years can therefore be predicted.

³⁶⁹ Eric Merson and Chris Hatton, Estimating future needs of social care among adults with learning disabilities in England: An update 2011.

³⁷⁰ Public Health England: how many people have learning disabilities? Available at: <http://www.improvinghealthandlives.org.uk/numbers/howmany/laestimates/> accessed June 2013.

Figure 6.19 Age profile of estimated numbers of people with learning disabilities in Waltham Forest



There were 798 with learning disabilities aged 18+ years recorded on GP practices' QOF registers in 2011/12. GP practices' records of prevalence of learning disabilities shows that the largest number of PLD is in Leyton/Leytonstone (385), followed by Walthamstow (304) and Chingford (109).

Transition

Research by Lancaster University shows that there will be an increase in young people reaching adulthood with complex needs over the next few years with a peak between now and 2020. Local evidence for Waltham Forest over the last 3 years based on the number of people transferring to adult services has shown that approximately 80% of the people requiring adult Health and Social Care services are likely to be young people with a significant learning disability with additional complex needs such as challenging behaviour, complex health and physical needs.

Fifty-seven young people who reached 19 years transferred to adult services in 2011/12 with 32 of them having a significant learning disability and requiring input from Health and Social care. In addition to this 87 young people known to children's services with an education statement reached the age of 18 years.

A decision was made by the Borough of Waltham Forest to transfer people to adult services at 18 years rather than the old arrangements of 19 years and 2 terms, this has created an additional pressure in adult services.

A transition team comprising of career advisors, social workers, a health facilitator and a manager has been established and is working with young people from the age of 14 years, this is the point when the transition planning commences.

New SEN reforms mean that young people will cease to have an education statement and there will be a requirement to develop a single health, education and social care plan for children from 0 to 25 years. This will require Health, education and social care services to work in a more integrated way when supporting children and young people with a disability.

The borough are required to develop a Local Offer which all key agencies will be responsible for implementing.

Mortality

People with learning disabilities die at younger ages than other people.

The median age at death for people with learning disabilities in Waltham Forest between 2008–11 was 26 years, which is significantly worse than England average 56 years, London average 49 years and both our statistical comparators Croydon 54 years and Greenwich 56 years. Again there has been a drop in age at which people with learning disabilities are dying in Waltham Forest from 33.5 years in 2006–10 to the current age of 26 years³⁷¹.

Nationally, respiratory disease accounts for 46% to 52% of deaths among PLD, which is higher than that of the general population between 15% and 17%. It is the highest cause of death among PLD. People with Down's syndrome are particularly at risk because they have a predisposition to lung abnormalities, a poor immune system and a tendency to breathe through their mouth.

CHD is the second most common cause of death among PLD. PLD are more likely to develop hypertension and obesity and they also suffer from lack of exercise, all of which increase the risk of Ischaemic heart disease (14%-20%). Between 40 and 50% of people with Downs' syndrome are affected by congenital heart defects. In Waltham Forest 6% of those who had annual health checks were found to have heart disease.

Smoking rates among PLD have been reported to be comparable to those in the general population or even higher. Smoking is higher among people with mild/moderate learning disabilities and this is mostly among those who live in private households.

Long-term conditions among PLD

PLD experience a higher prevalence of health conditions/risk factors compared to the general population. For example in PLD:

- Obesity – 1 in 3 PLD
- CHD – 2nd most common cause of death
- Respiratory disease – 3 times higher than the general population
- Dementia – 4 times higher than the general population
- Epilepsy – 20 times more common among PLD
- Sudden unexplained death in epilepsy – 5 times more common in PLD than in others with epilepsy.

³⁷¹ Public Health England (PHE), Learning disabilities profiles 2013.

Other major health problems among PLD include:

- Sensory impairment
- Osteoporosis
- Hypothyroidism (particularly in Down's syndrome)
- Mental illness and challenging behaviours and early onset of dementia
- Poor oral health
- Gastrointestinal disorders (e.g. gastro-oesophageal reflux disease)
- Cancer (particularly gastrointestinal cancers).

PLD have a much higher risk of developing epilepsy, particularly if they have severe learning disabilities. Nearly one in four (22%) have epilepsy compared with 1% of the general population line with the Waltham Forest findings. Of those who had an annual health check 22% were found to have epilepsy. Epilepsy is higher in Walthamstow.

PLD have a higher risk of developing dementia compared to the general population, with a significantly increased risk for people with Down's syndrome and at a much earlier age. About 20% of people with a learning disability have Down's syndrome, Dementia prevalence rates have been estimated at ten (with some studies as high as 25) in 100 people at 40 years of age, 36 in 100 people at 50 years and 50–65 people in 100 at age 60+. For those who have learning disabilities and do not have Down's syndrome, the prevalence rate is increased over the general population but at lower percentages than PLD with Down's syndrome. This approaches a level that is 4 times as great as the general population. Waltham Forest has 92 people with Down's syndrome, 29 of those are between the ages of 45–64 and out the 29, 5 suffer from dementia.

Of the PLD who had the annual health check in Waltham Forest, 35% were having care provided by older carers. Given that PLD are living longer and most require more than 50 hours a week of care, plans will be required for a number of PLD who may need their care provided by paid carers in future.

Challenging behaviour

People with all levels of learning disability and complex needs may display challenging behaviour. Emerson *et al.* found that people identified as having challenging behaviour were more likely to have additional health and social care needs such as restricted mobility (24%), visual impairment (15%), not fully continent (38%) or a need for assistance when washing (70%).

Findings in the studies of prevalence in challenging behaviour in people with learning disability vary widely, reporting rates of between 5.7% and 14%. The overall prevalence increases with age during childhood, reaches a peak during the age range of between 15 to 34 years and then declines. The Office of National Statistics estimates that 4% of PLD between the ages of 18 and 64 in England have challenging behaviour. PLD with challenging behaviour in Waltham Forest is 4.2% of those between ages 18 and 64 and this is similar to that of England. Prevalence across age groups is fairly equal, with the exception of a small increase between 25 to 44 years.

Complex health needs

People who have a learning disability and complex health needs are diverse. In Waltham Forest 4% of PLD fall into the complex needs category.

Autism spectrum disorder (ASD)

From the 741 people currently receiving services from the Community Learning Disability Team there is an estimated 0.9% of people who are either diagnosed as having ASD or are known to show characteristics of autism. There are more males than females which reflects national data. The National Autism Society estimates people with autism who have a learning disability to be at just under 50%.

Waltham Forest learning disabilities 2013 profiles figures show 376 pupils with a primary diagnosis of autism spectrum disorder are known to schools.

Waltham Forest learning disabilities profile

Public Health England provides annual local learning disabilities profiles that aim at showing:

- How many people have learning disabilities
- How healthy they are
- How much health care they get
- How well social services are looking out for them

2013 learning disabilities profiles³⁷² for Waltham Forest shows:

GPs are required to keep a register of patients on their practice list that have learning disabilities. In 2011/12 data the national average of people with learning disabilities known to their GPs is 4.54 in every 1,000. Although GPs in Waltham Forest are identifying more people with learning disabilities, our rate of 3.54 in every 1,000 is still significantly lower than England average. When compared to regional comparators, Waltham Forest rate is higher than London average (3.36) but lower than our statistical comparators Croydon (5.12) and Greenwich (3.89)³⁷³. A total of 798 adults with learning disabilities are known to GPs in Waltham Forest.

Waltham Forest rate of adults (18 to 64) with learning disabilities known to local authorities is 2.96 in every 1,000 which is significantly lower than England average (4.27), lower than London average (3.65) and also lower than our statistical comparators Croydon (4.2) and Greenwich (3.22). In 2011/12 a total of 510 adults with learning disabilities are known to local authorities. This is a drop of 8.9% from previous year (2010/11)³⁷⁴.

Estimates of children with learning disabilities are based on school children reported as having 'learning disabilities' on the 2011/12 annual school censuses. Waltham Forest rate of children with learning difficulties (specific difficulties (like dyslexia) moderate, severe and profound and multiple learning difficulties) known to schools of 36.12 in every 1,000 school pupils is significantly higher than England average (24.53) and twice as high as statistical comparators Croydon (15.22) and Greenwich (17). A total of 1,522 children with learning difficulties are known to schools in Waltham Forest. There are three specialist schools in the borough that provide education for children with a learning disability and complex needs. A transition team was set up in January 2013 to support children and young adults with an educational statement through the transition stage in to adult health and social care services. The team comprises of a health facilitator, social workers and career advisors and a team manager.

Waltham Forest proportion of eligible adults with learning disabilities having GP health check is 46.28 in every 1,000 which is significantly worse than England average (52.78). This is lower than London average (50.20) and statistical comparator Croydon (64.73) but higher than Greenwich (40.85). There has been a decline in the number of people receiving health checks in Waltham Forest, 405 in 2010/11 versus 342 in 2011/12.

³⁷² Public Health England (PHE), Learning disabilities profiles 2013. Available at: <http://www.improvinghealthandlives.org.uk/profiles/index.php?pdf=E09000031>. Accessed October 2013.

³⁷³ Self-Assessment Framework (SAF), 2012/13 data.

³⁷⁴ Public Health England (PHE), Learning disabilities profiles 2013.

The most recent data (2008/09) show Waltham Forest has significantly worse emergency admission to hospital for people with learning disabilities (65.87% of all emergency admissions) compared to England average of 49.96% and London average of 37.11%. This is also higher than Croydon (44.28%) and Greenwich (41.13%). This has implication for how patients experience care as advance planning is limited and therefore staff are not able to make reasonable adjustment in anticipation.

Similarly Waltham Forest has significantly higher admission rate for non-psychiatric care sensitive conditions in people with learning disabilities (46.54 in every 1,000 adults known as having learning disabilities) compared to England average (23.27) and London average (33.74). Equally Waltham Forest rate is higher than Croydon (21.55) and Greenwich (27.3). This indicator points to poor quality of community care for gastric-oesophageal reflux disorder (GORD), epilepsy and constipations which are the three conditions common in people with learning disabilities that are more likely to cause hospital admission.

Identifying people with learning disabilities in general hospital statistics is important in making appropriate reasonable adjustment in care for the patients. Waltham Forest's identification of people with learning disabilities in hospital is 21.37% which is significantly worse than England 27.1% and London average of 22.43%.

Figures for 2012/13 show that 75.3% of people with learning disabilities in Waltham Forest known to social services were living in settled accommodation compared to the London average of 67.7%. The target for 2013/14 is 76%³⁷⁵.

The rate of adults with learning disabilities using day care services supported by the local authority in Waltham forest is 225.49 per 1,000, which is similar to London average 282 and significantly lower than England average of 347.2.

There are 735.29 per 1,000 Adults with learning disabilities receiving community services supported by local authorities in Waltham forest, which is similar to England average of 746.71 and higher than London average of 669.49.

In 2012/13 11.3% of people with learning disabilities in Waltham Forest were in paid employment. This is slightly better than the London average (9.4%). The target for 2013/14 is 12%.

Waltham Forest adult social care service spend significantly more per head on people with learning disabilities £41.01 compared to England average (£21.52) and London average (£26.59). There has been a significant increase in spend per head, from £26.58 in 2010/11. Waltham Forest is spending more per head compared to our statistical comparators Croydon (£34.35) and Greenwich (£30.59) and generally having poorer outcomes.

What are effective interventions?

There are several government policies and service development frameworks that influence attitudes and services for people with learning disabilities. These policies and frameworks focus on promoting and delivery advocacy, employment support, person-centred planning, quality of life, effective transitions from children to adult services, improved support for families and partnership working to improve the lives of people with learning disabilities. A few of the policy drivers are summarised below:

Valuing People (DH:2001) – White Paper sets out the Government's commitment to improving the life chances of people with learning disabilities, through close partnership working to enable people with learning disabilities to live full and active lives.

Valuing People Now (DH:2009) – retained the principle outlined in Valuing People that people with learning disabilities are people first, and re-emphasised the need for agencies to work together to achieve the best outcomes for people with learning disabilities.

³⁷⁵ Self-Assessment Framework (SAF), 2012/13 data.

Valuing Employment Now (2009) – sets out the Government's strategy to improve employment opportunities for people with learning disabilities.

Our Health, Our Care, Our Say (DH: 2006) – sets out the Government's idea for the future direction of health and social care community services.

Health Care for All (2008) – the report of the independent inquiry into death by indifference concluded that people with learning disabilities appear to receive less effective care than they are entitled to, with evidence of a significant level of avoidable suffering and a high likelihood that deaths are occurring that could be avoided. A total of 10 recommendations were made, all of which were accepted by the Department of Health and Valuing People Now.

Six Lives (2009) Ombudsman Report – the report of the Health Ombudsman into the cases highlighted in Death by Indifference highlighted some significant and distressing failures in health and social care services, leading to situations where people with learning disabilities experienced prolonged suffering and inappropriate care.

The Autism Act 2009 and Fulfilling and Rewarding Lives – sets a clear framework for all mainstream services across the public sector to work together for adults with autism.

The key themes and national priorities for people with learning disabilities are as follows;

Personalisation: to ensure that people have real choice and control over their lives and the services they receive.

Modernised Day Opportunities: to ensure that people are included in their communities with a focus on increased independence and being in paid work.

Fair Access to Health: to ensure that people have full and equal access to good quality healthcare for both physical and mental wellbeing from NHS.

Access to housing in the community: to ensure that people have options for housing and with a focus on home ownership and tenancies.

Make change happen: to ensure that partnership boards are more effective in delivering policies

What is being done locally to address learning disability?

Prevention and access to universal services: Preventive services focus on providing information, advice and advocacy support to people with learning disabilities to enable them to enjoy independent living.

Waltham Forest commissioned Learning Disabilities Advocacy Service through a collaborative arrangement. The services commissioned included one to one advocacy, complex and high support professional advocacy, service users inclusion service (People First), Learning Disability Experience and Service Users Forum.

Waltham Forest also provides an advocacy support to young people (18–24) going through transition; these services empower young people through person-centred planning, independent and healthy living activities, community participation and development of friendships and relationships.

Supporting carers: Support for carers is a key part of support for vulnerable people. Support for carers also enables carers to continue with their lives, families, work and contribution to their community. Carers are able to access a range of services including low level preventive services to empower and enable them to have breaks.

Short Break (respite) Services: are available to people with learning disability through the Council's in-house respite care service and from independent providers. Respite care describes separate periods of care for people with learning disability if they, or their carer, need a short-term break. Respite care can also be provided in an emergency such as illness.

Self-Directed Support: Self-Directed Support is seen as being at the centre of personalisation. It is about giving people who use care and support services more choice and control over the support services they require. It enables people to take control of their own individual budget from which to commission and procure the care and support they feel will meet their individual needs.

People with Learning Disabilities also have access to Support Planning and Brokerage Services that will support them to set the outcomes they wish to achieve and plan how to spend their individualised budget. The service also supports individuals to arrange the services they require through a support broker. The resources allocation system was introduced to learning disability services in October 2011. All people who are assessed as requiring support from adult learning disability social care services are offered a personal budget which is based on their assessed needs. This gives people with learning disabilities the opportunity to use individualised budget to commission more person centred support in the community.

Community Learning Disability Team: is a multi-disciplinary and multi-agency team that includes a range of professionals (including consultant psychiatrist, community learning disability nurse, social worker, physiotherapist, occupational therapist, speech and language therapist, clinical psychologist and administrative support) and acts as the gate-keeper to services for adults with a learning disability living in Waltham Forest. The team is managed by North East London Foundation Trust.

Supporting living opportunities: Housing support services are intended to help people live independently in their own homes and provide early intervention and preventative services e.g. to prevent homelessness.

Supported living offers people with learning disability the opportunity to live in their own home in the community and to lead active, socially inclusive lives. The support is designed individually, with the active participation of the person to be supported and those who know them best. It focuses on what people can do, provides support for things people cannot do, and creates opportunities for people to learn how to do things they want to do.

Most importantly supported living offers choices to people about where they live; who they live with, what support is required and who offers it. Supported living has the potential to ensure that each individual's needs wishes and aspirations are met in a way, which suits them, and the lifestyle they want to lead. Approximately, 90 commissioning service users are currently been supported in Supported Housing in Waltham Forest.

Day Opportunities: Day Opportunities services are available for people with learning disabilities including Day Services for Asian Women, Supported Employment Project. Day opportunities are also commissioned from external providers. Day opportunities need to reflect the principles of personalisation, fit for purpose, modern and ensure that services are targeted at the people most in need. A review of day services will be completed this year for all adult services which includes resources for people with a learning disability.

Residential/Nursing Care: The policy drive at both national and local level is to move away from residential care provision for people with learning disabilities. In Waltham Forest a considerable percentage of service users are still placed in residential care partly because of the legacy of the long stay hospital which was located in the borough, the total number of both in and out of borough placements is 193. This represents approximately 26% of people receiving services from the Community Learning Disability Team.

One of our strategic priorities is to reduce the use of residential care and the strategic approach will be outlined in the commissioning strategy for people with learning disabilities which will be produced shortly.

Equalities It is broadly recognised that people with learning disabilities experience inequality in service provision and social outcomes when compared with people without learning disabilities. They also experience poor health, risk of early death and significant discrimination in accessing health care facilities, diagnosis and treatment as highlighted in the March 2007 Mencap report, 'Death by indifference'. The report accused the health services of institutional discrimination that led to people with a learning disability receiving worse health care than non-disabled people. This led to a confidential enquiry into the premature deaths of people with a learning disability, this was published in March of this year and recommendations published in the summer. The recommendations have been incorporated into a Waltham Forest report with local recommendations.

Waltham Forest embraces the principles of equality and celebrates the diversity of Waltham Forest's communities. Waltham Forest therefore will:

- Monitor performance against local population to ensure that policies and work practices meet the needs of the different communities
- Reduce barriers to services in terms of gender, disabilities, race, religion, sexuality and age
- Monitor service delivery to ensure equal access for all people requiring services
- Monitor take up of services
- Train staff to recognise diversity, promote equality and inclusiveness.

Equality Analysis will be carried out as part of the development of the Learning Disability Commissioning Strategy.

Safeguarding: Waltham Forest and all partner agencies aim to protect and promote individual rights, independence and well-being. This also includes an assurance that vulnerable people are safe and are safeguarded against abuse, neglect, discrimination and poor treatment. And, that they are treated with dignity, respect and enjoy a high quality of life. The Safeguarding process is detailed in the Safeguarding Operational Guidance Manual. The manual outlines the roles and responsibilities of care management, commissioners, providers and other agencies.

The Winterbourne View report and recommendations have been incorporated into a Waltham Forest action plan and will be monitored and reviewed through the Safeguarding Adults Board.

What evidence is there that we are making a difference?

- Health facilitators who are part of the learning disability team work with GP practices, and support people to receive annual health checks, they work with the other health and social colleagues in the team to provide a community-based service
- The LD team work with individuals around provision of 'reasonable adjustments' and links with the local hospital and GPs. The team also run groups for people to support their knowledge of services and prepare them for medical interventions
- Health promotion groups are run by the community learning disability nurse to promote such things as healthy eating, exercise and sexual health awareness
- People with learning disabilities and who have multiple health needs or two or more long-term conditions and are known to the social care services have a named health professional to coordinate their care

- The team have developed 'hospital passports' (patient held note with key information about the person) for people with learning disabilities which make it easier for professionals to be aware of their medical needs and make reasonable adjustment as appropriate
- The team works with GP through Directly Enhanced Service (DES) scheme for annual health checks and develop health action plans
- The team provide Specialist OT, Physiotherapy, speech and language, occupational therapy, psychiatry, psychology and community nursing services
- The team assess people for continuing health care funding.

Health and social care cases known to the team are prioritised using a RAG rating, red and amber cases are discussed at a weekly zoning meeting. People with complex health needs, presently in inpatient beds, at risk of hospitalisation or due for discharge will be discussed at the weekly meeting.

The impact of service provision for people with learning difficulties is measured against a number of key targets and indicators. Key national-level indicators include:

- National Indicator 145: Adults with learning disabilities in settled accommodation 439 users in 2012/13
- National Indicator 146: Adults with learning disabilities in employment 66 users in 2012/13
- National Adult Social Care Outcome 1E: Proportion of Adults with a Learning Disability in paid employment: 11.3% (66/583)
- National Adult Social Care Outcome 1G: Proportion of Adults with a Learning Disability living in their own home or with family: 75.3% (439/583).

In 2012/13 performance data showed only 439 of adults with learning disabilities in settled accommodation out of the recorded data on Framework (social care database). During the same period, only 66 adults with learning disabilities were in employment, this figure represents approximately 11.3% of those known to the Community Learning Disability Team.

As part of the health services Direct Enhanced Services (DES) scheme GPs have the option to sign up to the direct enhances service for learning disabilities. Requirements under this scheme are that GP practices will keep a register of all people with learning disabilities that are known to Social Care and Health Services. In addition the clients on the Learning Disability register will be offered an annual health check.

The community Learning Disability nurses monitor this process, validate the learning disability registers, provide learning disability awareness training and visit GP practices to monitor outcomes of the health checks and health action plans.

In 2011/12 342 health checks were completed for adults with learning disabilities within Waltham Forest. This is a reduction from the previous year and the community Learning disability nurses are continuing to promote the importance of annual health checks with GP practices and offer support to raise awareness of the importance of health checks to hard to reach patients.

Table 6.17 below shows the type and number of people with learning disabilities who received services in 2013/14.

Table 6.17 Number of PLD who received specific services in 2013/14

Service type	Number of people
Community Nurses	109
OT	49
Home care (brokerage)	15
Residential care (out of borough)	121
Residential care (in borough)	72
Day opportunities (in-house)	110
Day opportunities (spots)	85
Supported living accommodation (in borough)	122
Supported living accommodation (out of borough)	15
Floating support	44
Direct payment/individual budget	102

Sources of Data: The data has been collated from various sources, these include LP12 Review reports; activities returns for NI145 and 146; Finance database; service area records; and GP registers.

What is the perspective of the public on support available to them?

The Learning Disability Partnership board provides a platform for a regular dialogue with people with learning disabilities and their carers to inform the board about their experiences and to discuss issues they face in accessing services.

It is also a local forum to enable users and carers to have a say and for commissioners to gain insights into their needs and aspirations.

What more do we need to know?

Waltham Forest signed up to the Learning Disabilities Self-Assessment Framework which requires all providers to evidence how they identify and effectively engage with people with learning disabilities and where there are poor performance to demonstrate how they will improve. This is independently validated by NHS London.

The Self-Assessment Framework (SAF) outlines four main Top Targets and Key Objectives to be assessed. These include:

1. People who are or who were formally in NHS-provided long-term care have settled accommodation that reflect their Person-Centre Plans and there is a system in place to ensure minimum annual review.
2. Health and Social Care commissioners are working closely with local Partnership Boards, statutory organisations and other partners to address the health inequalities faced by people with learning disabilities.
3. People with learning disabilities who are in services that the NHS commissions or provides are safe.
4. Progress is being made in developing local services for those needing more help with their health.

Every year the NHS holds local events to assess the experiences of people with learning disabilities and their carers. The outcomes of these events inform the performance of Waltham Forest on the four top key targets and objectives areas listed above. These are submitted to NHS London who validate and confirm the local scoring.

In 2010, Waltham Forest scored one RED and three AMBERS; the RED score was due to one person still living in a long stay NHS bed. However, in 2011, the scoring has improved to one GREEN and three AMBERS. This shows that Waltham Forest still has areas that need improvement as shown in Table 6.18 below.

For 2012 the LD SAF return changed from four target areas to three. In addition the questions that were asked of providers and commissioners changed. This resulted in less evidence being available for specific target questions as there was no prior warning of the changes resulting in providers and commissioners not having adequate time to change their monitoring parameters to accommodate the changes. This resulted in a drop of scoring to all ambers, which NHS London at the time were expecting across the London region.

The LD SAF for 2012/13 has not yet been completed. Due to further significant changes to the document and the evidence is required the submission date for this return has been moved from July 2013 to 30 November 2013. Within the present LD SAF greater evidence is being requested from commissioners to monitor their awareness of how provider services perform.

Table 6.18 Waltham Forest's performance on the four top key targets and objectives areas

Target	2011 validated outcome	2012 validated outcome
Target 1: Access to Health (2012)	Green	Amber
Target 2: Being Safe (2012)	Amber	Amber
Target 3: Governance and Quality (2012)	Amber	Amber
Target 4:	Amber	N/A

For the 2011/12 the SAF changed putting great emphasis on health commissioners to demonstrate that their strategies, reasonable adjustments and commissioning activity reflects the need of the local learning disability population.

What are the priorities for improvement over the next 5 years?

Estimates suggest that the prevalence of people with learning disabilities will increase in the next few years; this is driven by four main factors (Emerson and Hatton 2004):

1. The increase in proportion of younger adults who belong to South Asian communities, as these communities have a higher prevalence of severe learning disabilities. Waltham Forest has a large population of people from these communities.
2. Increased survival rates among young people with severe and complex disabilities.
3. Increased longevity among adults with learning disabilities, due to improvements in medical care and reduced mortality.
4. The number of older people with older age related illness is increasing.

With this in mind, the priorities for the next five years include:

- To commission services in line with the expected increase in prevalence of people with learning difficulties over the next five years and develop services to meet the needs of people with learning disabilities locally
- Improve the quality of primary care learning disability register, ensuring that there are systems in place to ensure more people with learning disabilities are identified and added to the register; services are reasonably adjusted to meet the health needs of people with complex needs

- To ensure that all the key targets and objectives in the Self-Assessment Framework are met and to ensure that there is continued improvement in services for people with learning disabilities
- To help people with learning disabilities to understand personalisation and individualised budget, how to spend their budgets and what choice and control mean to them
- Partnership working to address health inequalities and engaging with people with learning disabilities who have complex needs and involving them in making choices about their health
- Encourage uptake of annual health checks and improve access to screening services and other services in line with Valuing People, Six Lives and Health Care for All recommendation
- To continue to work positively with local sexual health services through the provision of regular appointments and follow-up, support and education
- Strengthen partnership working and develop closer relationship with the voluntary sector to promote health and the wellbeing of PLD
- Continue to develop better well-co-ordinated systems to plan for young people going through transition to adult services
- Review community care for people with learning disabilities to identify ways of reducing rate of emergency admission in this group and provide a service which promotes a preventative and enabling model
- Ensure that Waltham Forest keeps abreast of any other developments as a result of the recommendations made by the Confidential Enquiry, for example the resuscitation guidelines
- To ensure that social care and health policy include the needs of people with a learning disability
- To embed the recommendations of the Health and Care Bill and the Children and Family Bill and incorporate the needs of people with a learning disability.

Autism

The Autism Act 2009 and the National Strategy for Autism 'Fulfilling and rewarding lives, is the first disability specific strategy for adults with ASD in England. This legislation requires local authorities and NHS to implement a local autism plan to meet the needs of those people on the autism spectrum.

Waltham Forest has developed a Joint Children and Adults Autism Strategy and is expected to present this to Cabinet in December/January to agree its implementation.

What is autism?

Autism is defined as: 'A disorder of neural development characterized by impaired social interaction and communication and by restrictive and repetitive behaviour'.

There are three main types of ASD:

- autistic disorder, sometimes known as 'classic autism'
- Asperger syndrome
- pervasive developmental disorder – not otherwise specified (PDD-NOS), also known as 'atypical autism'.

People with autism have a wide spectrum of needs and are unique with no two people are the same. There are three key areas of difficulty known as the 'triad of impairments' that all people with autism are likely to experience:

- Ability to understand and use non-verbal and verbal communication
- Ability to understand social behaviour and to interact with other people
- Ability to think and behave flexibly.

In addition, many people with autism are over-sensitive or under-sensitive to particular things such as smells, tastes, colour, sounds, balance or touch.

Autism is a lifelong developmental that affects the way a person communicates with, and relates to, people and the world around them. Those with higher functioning autism or Asperger Syndrome feel they have a 'hidden' condition not easily recognised or understood by professionals or the general public.

Some people with ASD may have accompanying conditions such as Learning Disabilities, Mental Health, ADHD and/or epilepsy. For some people with ASD they may find themselves in a position where they do not fit easily into Learning Disability or Mental Health services and therefore may not have access to appropriate services to meet their needs.

Research

Data from the PANSI website (2013), a system developed by the Institute of Public Care (IPC) to assist local authorities to gather data predicts that there are 1,784 people living in Waltham Forest with Autism Spectrum Disorder; with this number predicated to increase to 1,833 by 2015.

Recent prevalence estimations of autism spectrum conditions shows the overall prevalence of autism, combining data from the Adult Psychiatric Morbidity Survey (APMS) 2007 and learning disability study, was 1.1 per cent (95 per cent confidence interval 0.3 per cent to 1.9 per cent). The prevalence of autism was higher in men (2.0 per cent) than women (0.3 per cent). If this data is applied to the population of Waltham Forest, it would suggest there are 2,840 people with ASC locally.

Currently local data is not clearly documented, including BAME data on the number of Children and Adults with Autistic Spectrum Disorder in Waltham Forest. The delivery plan in Waltham Forest's draft joint autism strategy seeks to address this gap and improve current systems. Other factors that may contribute to the lack of data of those with ASD may be:

- lack of early diagnosis and clear pathways
- those with high functioning ASD not meeting eligibility criteria.

Table 6.19 provides data based on open referrals between April 2012 and March 2013.

Table 6.19 Open referrals April 2012 to March 2013

Category	Number
Number of adults with a diagnosis of autism:	65
Number of adults open to LD services only	42
Number of adults open to LD and mental health services	7
Number of children with a diagnosis of autism and open to CAMHS services	65

Below are figures relating to people with a diagnosis of Asperger's.

Table 6.20 People diagnosed with Asperger's syndrome

Category	Number
Number of adults with a diagnosis of Asperger's syndrome	29
Number of adults with Asperger's open to LD services only	1
Number of adults with Asperger's open to LD and mental health services	6
Number of children with a diagnosis of Asperger's syndrome, open to CAMHS services	22

Current data shows 7 people who have autism and accompanying learning disabilities are in receipt of Direct Payments.

It is important for those people with ASD who do not meet the eligibility criteria for adult social care, that they are signposted to other services so they are not left without appropriate support, this includes advocacy services. The Government guidance for local authorities emphasises to focus on prevention rather than crisis management.

The National Audit Office (NAO) investigated public spending for adults with autism and found if local services identified and supported just 4% of adults with High Functioning Autism and Asperger syndrome the outlay would become cost neutral over time. Furthermore, they found if they did the same for just 8% the Government could save £67 million per year. Although an initial cost with identification will be placed on the NHS – estimated to be around £28 million for an eight per cent identification rate – the saving for local authorities would potentially be around £105 million.

Research has shown only 15% of adults with autism in the UK are in full-time paid employment, with 51% of adults with autism in the UK having spent time with neither a job, nor access to benefits.

NAS website states some people with autism may be vulnerable to criminal acts against them because of their social difficulties. It is therefore vital that appropriate support needs to be in place in order that victims are understood and appropriately represented and supported.

Waltham Forest priorities

Key priorities for Waltham Forest is raising awareness, training, establishing clear diagnostic pathways, transition, housing, employment, personalisation, carer support and support in the criminal justice system.

As autism awareness becomes more ingrained and professionals and key agencies become more aware of the needs of individuals with autism spectrum disorder, the demand for services is likely to grow.

Both Social Care and Health will need to be able to meet this demand and commission services that have skilled workers who can deliver good quality, and offer value for money.

Waltham Forest has a range of services provided in-house and commissioned from the voluntary and independent sector that children, young people and adults including those with Autism Spectrum Disorder can access. Mapping of these services are currently underway to understand what the demands are for specific/specialised services, the costs of these and to ensure that service provision is delivering good quality and value for money.

We anticipate that gaps are more likely to be apparent for those people with ASD who are high functioning, compared with those people with lower functioning levels.

6.5 Neurological conditions

Executive summary

This section considers four long-term neurological conditions; Epilepsy, Parkinson's disease, Multiple Sclerosis and Motor neurone disease.

- Among those aged 18 or over and registered with a GP in Waltham Forest, there are 1,228 people who have diagnosed epilepsy. This is a local rate of 0.5% (crude rate), and compares to a London rate of 0.6% and an England rate of 0.8%³⁷⁶. There is little or no breakdown of ethnicity of patients available
- It has not been possible to obtain data on the number of people in Waltham Forest with Parkinson's, Multiple Sclerosis or Motor neurone disease, however national rates were applied to the local population, resulting in the following estimates for Waltham Forest:
 - Parkinson's – a rate of 195 per 100,000 or 506 individuals³⁷⁷
 - Multiple sclerosis – a rate of 161 per 100,000 or 418 individuals³⁷⁸
 - Motor Neurone disease – 7 per 100,000 or 18 individuals³⁷⁹.

Waltham Forest's spend per head for neurological conditions was £74 for 2011/12. This is compared to £64 per head of population for our ONS cluster (London suburbs).³⁸⁰

Recommendations

- **Provision of a specialist nurse for those with Parkinson's disease**
The neurology consultants support the view that **a community nurse specialist for Parkinson's and MND patients** would not only improve the care provided for these groups but would also relieve the burden on hospital services, improve the numbers of people treated within the borough and help with issues faced by those suffering from these conditions before they escalate. Parkinson's UK has **offered to seed-fund a post using a patient legacy**: the option for this funding should be explored.
- **A paediatric epilepsy nurse specialist based at Whipps Cross**
Whipps Cross has a paediatric neurology clinic and an epilepsy clinic **but no paediatric epilepsy nurse specialist**. The number of young people with epilepsy seen at Whipps Cross (emergency and other admissions) should be compared to other similar boroughs, to explore this need further.
- **Increased communication (2012/13 recommendation)**
Although a specialist nurse for MS is now in place, some cases are not being referred on from the GPs for extra support provided by the nurse. When patients with neurological conditions are admitted to hospital, there can be a delay where hospital staff are not aware of the diagnosis, therefore appropriate medication may be delayed.

³⁷⁶ Health and Social Care Information Centre (HSCIC), QOF 2011/12.

³⁷⁷ Parkinson's UK, <http://www.parkinsons.org.uk/content/about-parkinsons>

³⁷⁸ Multiple Sclerosis Society, <http://www.mssociety.org.uk/>

³⁷⁹ Motor Neurone Disease Association, <http://www.mndassociation.org/what-is-mnd/Brief+guide+to+MND.htm>

³⁸⁰ CCG Spend and Outcome Factsheet and Tool, <http://www.yhpho.org.uk/quad/Default.aspx>

- **Assessment of available mental health services (2012/13 recommendation)**

Current provision within the borough is not sufficient for those with long-term neurological conditions. Those with MS are at particular risk of depression and even suicide. As there is an overlap between Parkinson's disease and Lewy Body Disease there is an accompanying need for review by old age psychiatry/memory services.

A mental health strategy is in development in the public health team and the needs of patients with long-term neurological conditions should be picked up in this strategy.

What is a long-term neurological condition?

A long-term neurological condition results from damage to or disease of the body's nervous system. These can be broadly categorised as follows:

- **Sudden onset conditions** – e.g. stroke or T.I.A
- **Progressive conditions** – e.g. motor neurone disease, Parkinson's disease
- **Intermittent/unpredictable conditions** – e.g. multiple sclerosis, epilepsy
- **Stable neurological conditions** – e.g. cerebral palsy, post-polio syndrome.

These can cause a range of problems for the individual, including impaired movement, muscle weakness, coordination problems, seizures and paralysis.

This section focuses on four key long-term neurological conditions:

Epilepsy

Epilepsy is the most common chronic disabling neurological condition in the UK. It is characterised by recurrent seizures, and classified as an intermittent condition. Epileptic seizures are the clinical manifestation of abnormal, excessive or synchronous neuronal activity in the brain. Epilepsy can have many causes and should be seen as a symptom of different neurological disorders, rather than a single disease entity. Epilepsy affects the brain and causes repeated seizures, also known as fits. Epilepsy usually begins during childhood, although it can start at any age.

Epilepsy can be caused by a head injury, an infection (for example meningitis) or a stroke, and it can also be inherited. Much of the time, however the reason a person develops epilepsy is unknown.³⁸¹

Epilepsy affects around about 1 in 100 people in the UK, totalling approximately 500,000 across the country.

Parkinson's disease

Parkinson's disease is a progressive neurological condition in which part of the brain becomes damaged over many years. The cause of Parkinson's remains unknown, but the disease is characterised by a lack of dopamine-containing cells in the movement-centre of the brain, resulting in three main symptoms related to movement:

- Involuntary shaking of particular parts of the body (tremor)
- Muscle stiffness that can make everyday tasks such as getting out of a chair very difficult (rigidity)
- Physical movements become very slow (bradykinesia).

³⁸¹ Epilepsy Society, <http://www.epilepsysociety.org.uk/epilepsy-did-you-know>

It is not known why people get Parkinson's disease. Most people are aged over 50 when symptoms first manifest, however one person in 20 is under the age of 40 [Parkinson's UK]. There is currently no cure for Parkinson's disease.

The prevalence of Parkinson's disease in the UK is estimated at 195 per 100,000, which equates to around 127,000 people.³⁸²

Multiple sclerosis

Multiple sclerosis (MS) is a disease affecting nerves in the brain and spinal cord, causing problems with muscle movement, balance and vision. In those suffering from MS the protective myelin sheath surrounding the nerves in the brain breaks down, disrupting the transfer of nerve signals. This causes a wide range of potential symptoms, such as loss of vision, ataxia and fatigue. MS is more common among women than men, with the most likely time for diagnosis between 20 and 40 years of age.

The rate of MS in the UK is around 161 per 100,000, which equates to 100,000 people living with the condition in the UK.³⁸³

Motor neurone disease

Motor neurone disease (MND) is a rare condition that progressively damages the nervous system, causing the muscles to waste away. As the condition progresses, people with motor neurone disease will find walking, speaking and even breathing and swallowing increasingly difficult, and eventually impossible. The cause of this condition is currently unclear, although there are a number of theories.

Men are slightly more likely to acquire MND as women, with the majority of people being over 40 years of age at diagnosis, and the highest incidence between the ages of 50 and 70.

The rate of MND in the UK is 7 per 100,000, which equates to around 4,400 people with the condition.³⁸⁴

What is the local picture?

Epilepsy

The proportion of patients with epilepsy on drug treatment and convulsion free is 75.38 (72.61%–77.95%) in Waltham Forest, compared with 72.63% (72.14%–73.11%) in London and 74.68% (74.52%–74.84%) in England.³⁸⁵

Parkinson's disease

The rate of Parkinson's disease in the UK is 195 per 100,000. Applied to the population of Waltham forest, this results in an estimate of 506 individuals with Parkinson's disease locally.³⁸⁶ As shown in Table 6.21, this can be split into the following phases:

Table 6.21 Parkinson's disease phase

Parkinson's disease phase				Total
Diagnosis	Maintenance	Complex	Palliative	
55	205	171	75	506

Source: NeuroNavigator, Neurological commission support (data accessed 11.11.2013) – <http://www.neuronavigator.org.uk/>

Between 2009 and 2010 there were 19 deaths attributable to Parkinson's in Waltham Forest (see Figure 6.22 below).

³⁸² Parkinson's UK, <http://www.parkinsons.org.uk/content/about-parkinsons>

³⁸³ Multiple Sclerosis Society, <http://www.mssociety.org.uk/>

³⁸⁴ Motor Neurone Disease Association, <http://www.mndassociation.org/what-is-mnd/Brief+guide+to+MND.htm>

³⁸⁵ Health and Social Care Information Centre (HSCIC), <https://indicators.ic.nhs.uk/webview/>

³⁸⁶ Parkinson's UK, <http://www.parkinsons.org.uk/content/about-parkinsons>

Multiple sclerosis

The rate of MS in the UK is 161 per 100,000. Applied to the population of Waltham forest, this results in an estimate of 418 individuals with Multiple sclerosis locally. As shown in Table 6.22 below, this can be split into the following phases:

Table 6.22 Multiple sclerosis phase

Multiple sclerosis phase				Total
Diagnosis	Minimum-moderate impairment	Complex	Palliative	
18	174	216	10	418

Source: NeuroNavigator, Neurological commission support (data accessed 11.11.2013) – <http://www.neuronavigator.org.uk/>

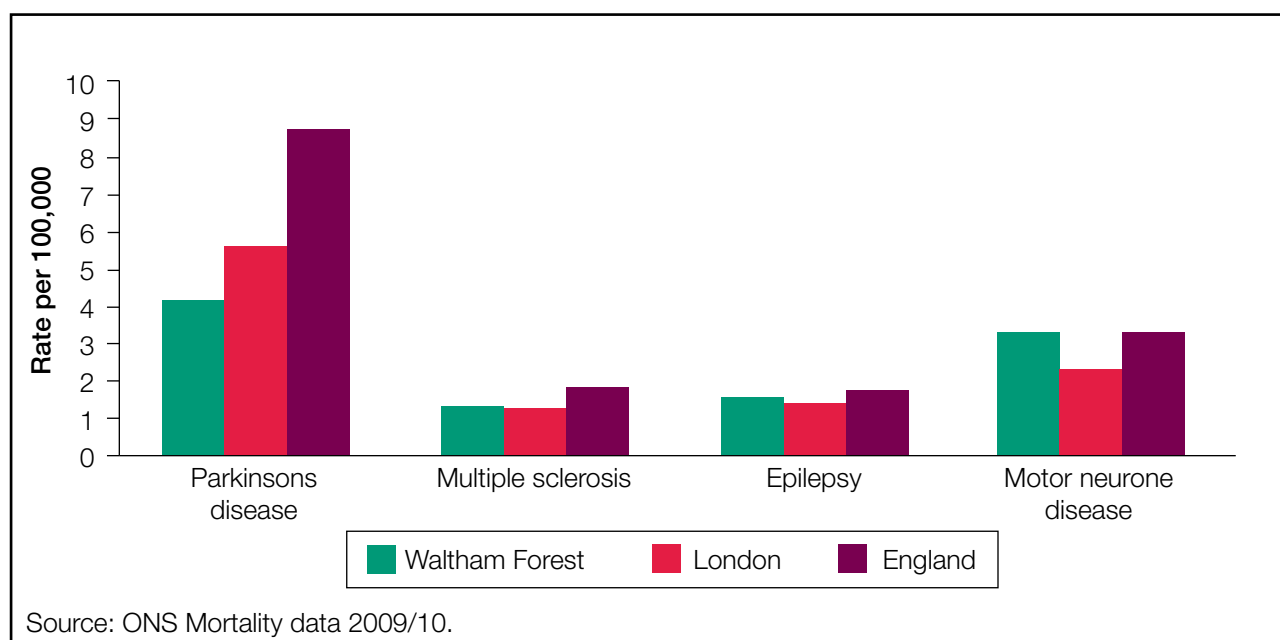
Between 2009 and 2010 there were 19 deaths attributable to MS in Waltham Forest. See comparison figure below.

Motor neurone disease

The rate of motor neurone disease in the UK is 7 per 100,000. Applied to the population of Waltham Forest, this results in an estimate of 18 individuals with motor neurone disease locally. Local services report they are currently treating 10 patients in Waltham Forest with this condition.

Between 2009 and 2010 there were 15 deaths attributable to MND in Waltham Forest (Figure 6.20 below).

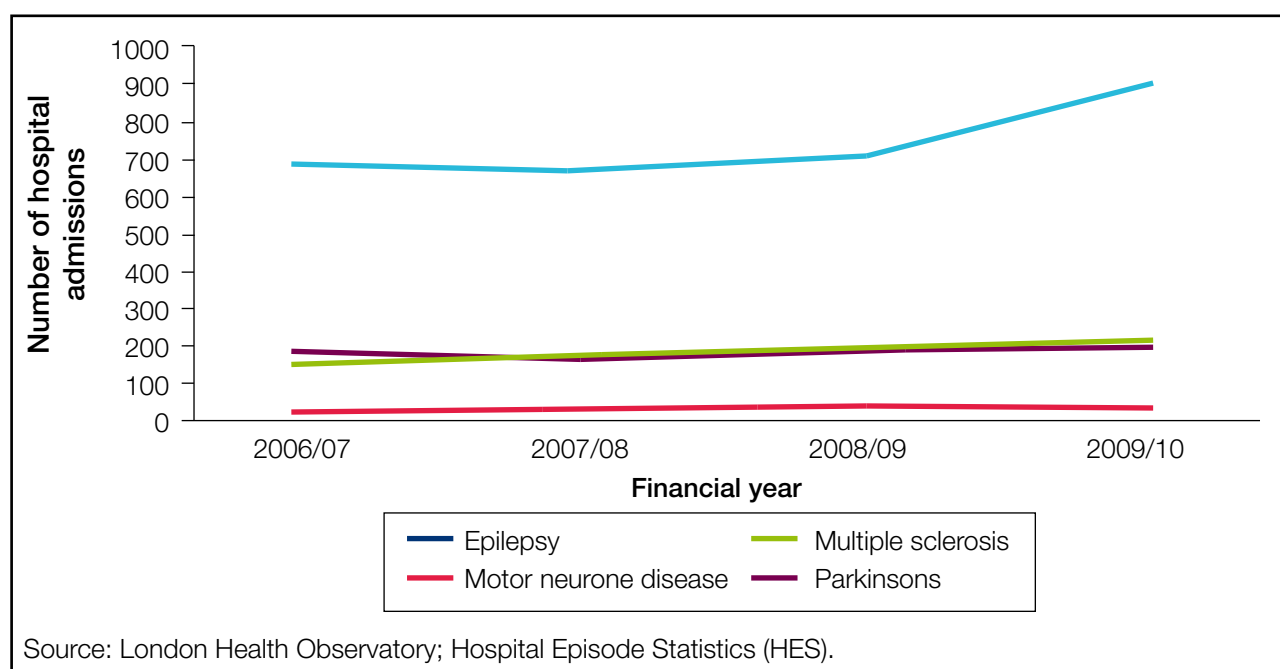
Figure 6.20 Age standardised death rates per 100,000 population, by neurological condition and area of residence, 2009/10 pooled data



Admission to hospital

Data from the London Health Observatory is available for years up until 2009/10. This shows that from these four conditions, epilepsy causes by far the greatest number of hospital admissions (886 for 2009/10). No further data has been made available since 2013/14. See Figure 6.21 below.

Figure 6.21 Number of hospital admissions, by neurological condition and financial year, Waltham Forest residents 2006/07 to 2009/10



What are the effective interventions?

Epilepsy

The NICE guidelines for epilepsy were updated in 2012. Some detail was given in last year's JSNA and the guidance can be accessed at:

<http://guidance.nice.org.uk/CG137>

Parkinson's disease

NICE issued guidelines for Parkinson's disease in 2006 and some detail of the guidance was provided in last year's JSNA. The guidance can be accessed at:

<http://publications.nice.org.uk/parkinsons-disease-cg35>

Multiple sclerosis

NICE issued guidelines for multiple sclerosis in 2003, and there are updated guidelines due out in 2014. Some detail of these guidelines was provided in last year's JSNA.

<http://publications.nice.org.uk/multiple-sclerosis-cg8>

Motor neurone disease

NICE guidance is at <http://publications.nice.org.uk/motor-neurone-disease-cg105>

There is also good practice guidance from the MND Association:

- Rapid and accurate diagnosis
- Earliest possible assessment by a neurologist
- Appropriate emotional/psychological support
- Appropriate information is made available, in a timely manner
- Immediate identification of a single point of contact (key worker/case manager)
- Access to appropriate expertise and services at the appropriate time
- timely referral to specialist palliative care and respite care
- Regular monitoring and review.

What is being done locally to address the needs of patients with neurological conditions?

Spend/outcome

Total spend for learning disabilities, neurological conditions, hearing, trauma and injuries and social care needs was slightly lower relative to other PCTs in 2011/12, however the overall outcomes for this category are equal to that of other PCTs³⁸⁷.

Waltham Forest's spend per head of population for neurological conditions was £74 for 2011/12. This is compared to £64 per head of population for our ONS cluster (London suburbs).

GP referral

GPs refer suspected cases of neurological conditions to consultants at Whipps Cross or other hospitals (mainly Royal London or Queens Hospital). For complex neurological problems it can sometimes be a long period before a problem is suspected and referred on. The specialist nurse services are advertised to all the GPs in the borough.

Secondary care

There are three half time consultants for neurological conditions based at Whipps Cross Hospital (time split between Whipps and the National Hospital) and one sessional consultant providing an outpatients clinic. The clinic is busy and it has been reported that waiting lists are long for non-urgent cases.

Specialist nurses

In 2009, a specialist nurse for MS post was created in Waltham Forest, conducting clinics, and home visits for regular reviews of patients. This has greatly increased the support to those with MS resident in Waltham Forest. Clinics are held at Chingford Health Centre (monthly), Whipps Cross (monthly) or the Comely Bank Clinic (weekly), and patients are referred on for other services as appropriate.

At present there is no specialist nurse to serve the needs of those with Parkinson's disease or MND. As well as providing community support, a specialist nurse would relieve the caseload for the hospital consultants. Parkinson's UK has offered some seed-funding for a nurse from a patient legacy: the CCG should explore this offer.

The Epilepsy Society and Whipps' consultants endorse the establishment of a paediatric epilepsy nurse specialist post.

Other services

Community rehabilitation – Intercare – provides rehabilitation for those in Waltham Forest. This can be provided in people's homes or in the Ainslie Rehabilitation Unit, which also takes inpatients.

Mental Health Services – cited by multiple sources as a potential gap, patients can be referred for counselling at Whipps Cross Palliative care centre, however that service is sometimes not sufficient for those with complex needs.

Family/carer support – apart from volunteer agencies, there is no particular support for children of those with MS. There is also little support available for carers of those with neurological conditions.

³⁸⁷ Spend and outcome factsheet 2010/11, Waltham Forest PCT. Yorkshire and Humber Public Health Observatory, Right Care and Department of Health.

Voluntary agencies

There are many voluntary agencies for those with neurological conditions working in Waltham Forest.

The MND Association provides community support for sufferers of MND.

Parkinson's UK provide monthly drop in groups for those with Parkinson's and their carers. They have said they may be willing to part fund a Parkinson's specialist nurse if an appropriate business case were submitted.

The Epilepsy Society identifies need in the borough through work with patients and carers and health professionals, and via community education workshops.

The MS Action Therapy Centre in Walthamstow has a weekly drop in clinic, and caters for people with all kinds of neurological conditions.

What is the perspective of the public on support available to them?

The Waltham Forest Local involvement network (LINK) conducted a review of neurological services in 2010, in which the following points were highlighted:

- Neurological conditions are not explicitly mentioned in the Waltham Forest Joint Commissioning Strategy, meaning that these service areas may be neglected against other priority areas. **Neurology is discussed in the CCG CSP for 2014/15**
- Specialist nursing services are currently limited to one MS nurse, and this service has only been operational since 2009. Budget pressures have prevented further commitments for specialist nursing services. This was highlighted as the main gap in services
- Relationships around commissioning and the Local Authority are good, however there needs to be more joint commissioning arrangements between social and neurological services to better integrate care
- Recommendations identified by previous PPI forum research into neurological services in the borough remain to be fully implemented. These include the establishment of person-centered services, set of multi-disciplinary teams working across neurological conditions, delivery of specialist nursing services and provision of support and assistance to carers.

What more do we need to know?

Epilepsy data is available through the primary care database (QOF) but is more difficult to obtain for other conditions, and is mainly estimated from national rates or from the number of cases being treated by specialist nurses. There is a paucity of data on the ethnicity of patients.

What are the priorities for improvement over the next five years?

Comments from those working in this sector have been that with the exception of the recruitment of a specialist nurse for MS, very little has changed in the service provision for those with neurological conditions for many years.

Provision of a specialist nurse for those with Parkinson's disease

The specialist nurse has greatly increased support for those with MS, and having this service for those suffering from Parkinson's and MND would not only improve the care provided for these groups but would also relieve the burden on hospital services, improve the numbers of people treated within the borough and help with issues faced by those suffering from these conditions before they escalate. NICE guidelines specify that those with Parkinson's should be reviewed regularly and have access to a specialist nurse, and unless they seek treatment out of borough, this is not available. Improvement of follow-up and maintenance of those with MND and Parkinson's should be a priority for the borough. Funding for the MS specialist nurse is only secured until December, and every effort should be made to ensure that this post continues in the borough.

Increased communication

Although a specialist nurse for MS is now in place, some cases are not being referred on from the GPs for extra support provided by the nurse. Also, when patients with neurological conditions are admitted to hospital, there can be a delay where hospital staff are not aware of the diagnosis, and there is no one to contact, therefore appropriate medication may be delayed.

Assessment of available mental health services

Current provision within the borough is not sufficient for those with long-term neurological conditions. Those with MS are at particular risk of depression and even suicide. Inclusion of this need in the mental health strategy in development (October 13) is essential.

6.6 Respiratory diseases

Executive summary

Respiratory disease is the third main cause of death in Waltham Forest and contributes to significant health inequality in the borough. Asthma is a long-term respiratory condition that can be debilitating in some individuals chronic obstructive pulmonary disease (COPD) is a progressive and debilitating respiratory disease that is a leading cause of health inequality in men in Waltham Forest, particularly from areas of high deprivation.

Both asthma and COPD are considered ambulatory care sensitive conditions (where admission to hospital is potentially avoidable through good quality primary and preventive care) but they result in high levels of hospital admissions locally. This indicates a weakness in primary care. Asthma and COPD are clinically different diseases but share similar risk factors, notably smoking and exposure to second-hand smoke. Deprivation is a key factor in poor health outcomes for both conditions. They are conditions that can be improved through similar objectives³⁸⁸:

- Ensure people are aware of the importance of good lung health, what the risk factors are and how to avoid them
- Reduce early deaths through proactive, accurate early diagnosis and interventions
- Enhance the quality of life for people with poor lung health across all social groups, with a positive and enabling experience of care and support
- Ensure people with asthma are free of symptoms, and people with COPD experience minimal disease progression, through accurate diagnosis, shared decision making, and ongoing support.

Recommendations

- Establish healthy workplace schemes in the largest employers in the borough (Local Authority and NHS). The schemes should address healthy living, early detection, and wellbeing initiatives that educate and de-stigmatise lung disease. Evidence shows that targeted schemes can result in a 34% return on investment
- Implement a two tier smoking prevention curriculum in local schools that address all students aged 13-14 through multi-media learning, and followed by a targeted programme of peer support and intervention for students in high need schools.

What is asthma?

Asthma is a chronic disorder of the airways, caused primarily by inflammatory processes and constriction of the smooth muscle in airway walls (bronchoconstriction). It is characterised by airflow obstruction and increased responsiveness of the airways to various stimuli. Symptoms include recurring episodes of wheezing, breathlessness, chest tightness and coughing. Typical asthma symptoms tend to be variable, intermittent and worse at night. Asthma is commonly triggered by viral respiratory infections, exercise, smoke, cold and allergens such as pollen, mould, animal fur and the house dust mite³⁸⁹.

³⁸⁸ A national outcomes strategy for COPD and Asthma 2011; Department of Health.

³⁸⁹ NICE 2012: NICE technology appraisal guidance: <http://www.nice.org.uk/nicemedia/pdf/TA138Guidance.pdf>

Prevalence

The prevalence of asthma in England is one of the highest in the world, with approximately 5.9% of the population with diagnosed asthma (2008)³⁹⁰.

Mortality

Nationally, the number of deaths from asthma has remained level since 2000, and it is estimated that 90% of those deaths are associated with preventable factors.

Risk factors

WHO³⁹¹ recommends that the fundamental causes of asthma are not completely understood. The strongest risk factors for developing asthma are a combination of genetic predisposition with environmental exposure to inhaled substances and particles that may provoke allergic reactions or irritate the airways, such as:

- indoor allergens (for example house dust mites in bedding, carpets and stuffed furniture, pollution and pet dander)
- outdoor allergens (such as pollens and moulds)
- tobacco smoke
- chemical irritants in the workplace
- air pollution.

What is COPD?

Chronic obstructive pulmonary disease (COPD) is a general term that includes chronic bronchitis and emphysema, and is characterised by airflow obstruction. The airflow obstruction is usually progressive, not fully reversible and does not change markedly over several months.

COPD is common, it is estimated that three million people are affected by COPD in the UK, equivalent to 2-4% of the population. An estimated two million people have COPD but much has not been diagnosed. Of those with undiagnosed COPD, 5% will have be at the mild end of the spectrum (see NICE).

Mortality

COPD is the fifth leading cause of death in the UK, accounting for 30,000 deaths each year, more than 90% of which occur in the over 65 age group.

Risk factors

- Most COPD cases are caused by smoking or exposure to second hand smoke. The lifetime risk of developing COPD as a smoker is 10 to 25%
- COPD cases caused by other risk factors such as air pollution, or polluted working conditions, are rarer in the UK than in other countries
- COPD is closely associated with levels of deprivation
- COPD mainly affects people over the age of 40 and becomes more common with increasing age.

Impact on the individual

Symptoms include cough, shortness of breath, and excessive sputum production. Chest infections are common. Exacerbations can result in hospital admissions. Breathlessness has a significant impact on quality of life.

Impact on business

COPD accounts for more time off work than any other illness.

³⁹⁰ Quality and Outcomes Framework 2008.

³⁹¹ WHO, Chronic Respiratory Disease: <http://www.who.int/respiratory/asthma/causes/en/index.html#>

Impact on NHS

Direct health care costs for COPD are an estimated £800 million³⁹².

The local picture – asthma

Prevalence

The recorded prevalence of asthma in Waltham Forest (as a percentage of GP practice list) was 4.5% in 2011. This is significantly better than the England average (5.9%) for the same year, and lower than the London average (4.9%)³⁹³. The expected prevalence in the borough is 9%, similar to the expected prevalence nationally and regionally. The gap between recorded and expected prevalence may represent under diagnosis. Refer to Maternal and Child Health section for asthma in children.

The local picture – COPD

(Unless stated, the following data has been supplied by the Interactive Health Atlas for Lung Conditions in England (INHALE)).

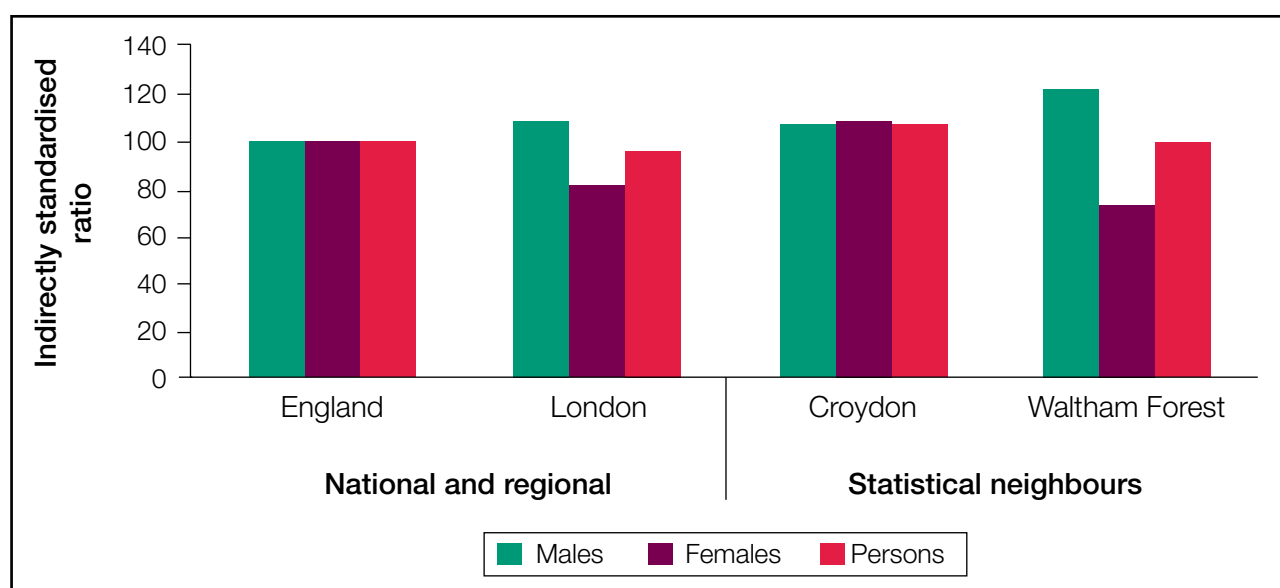
Prevalence

Between 2008–10, the recorded prevalence of COPD in Waltham Forest was 0.9%. In 2011 the recorded prevalence as a percentage of patients registered with local GP practices was 1%, equal to other London suburbs. Compared to England and London as a whole, recorded prevalence is lower. The expected prevalence of COPD is 3.2%. The gap between recorded and expected prevalence is bigger in Waltham Forest compared with the England average. The gap between recorded and expected prevalence is a measure of undiagnosed disease.

Mortality

The COPD mortality rate per 100,000 population under the age of 75 is reported as not significantly different from the England average. Mortality in those aged 75 and under is considered premature or early, death. Whilst the average rate of early death is not significantly different to the national average, local level data (2008–10) indicates that men in the borough have a higher early death rate due to COPD than their national counterparts. This is a similar profile to London as a whole and is compatible with higher smoking prevalence in men in the borough and London.

Figure 6.22 Under 75 mortality from COPD (2008–10 pooled)



³⁹² COPD An Outcome Strategy for Chronic Obstructive Pulmonary Disease (COPD) and Asthma in England July 2011; Department of Health.

³⁹³ INHALE data report/spinechart.

Health care services

Primary care

The majority of asthma and COPD management is done in primary care, including diagnosis, prescribing, monitoring, patient education and continuity of care. Good quality management of symptoms is essential to avoid admissions into hospital and to maintain quality of life.

Asthma and COPD are clinically different diseases that share some symptoms and risk factors. Accurate diagnosis is one of the most important tools for optimal treatment of both diseases.

The percentage of patients on asthma registers with Asthma diagnoses with Measures of Variability or Reversability was 88.5% in Waltham Forest, this is higher than local and regional averages (86.4% and 86.5% respectively) but not significantly higher than the England average (87.2%).

The percentage of patients on COPD registers with diagnoses confirmed by spirometry is 92.1%. This is not significantly different from the England average and higher than the London and local (London suburbs) averages.

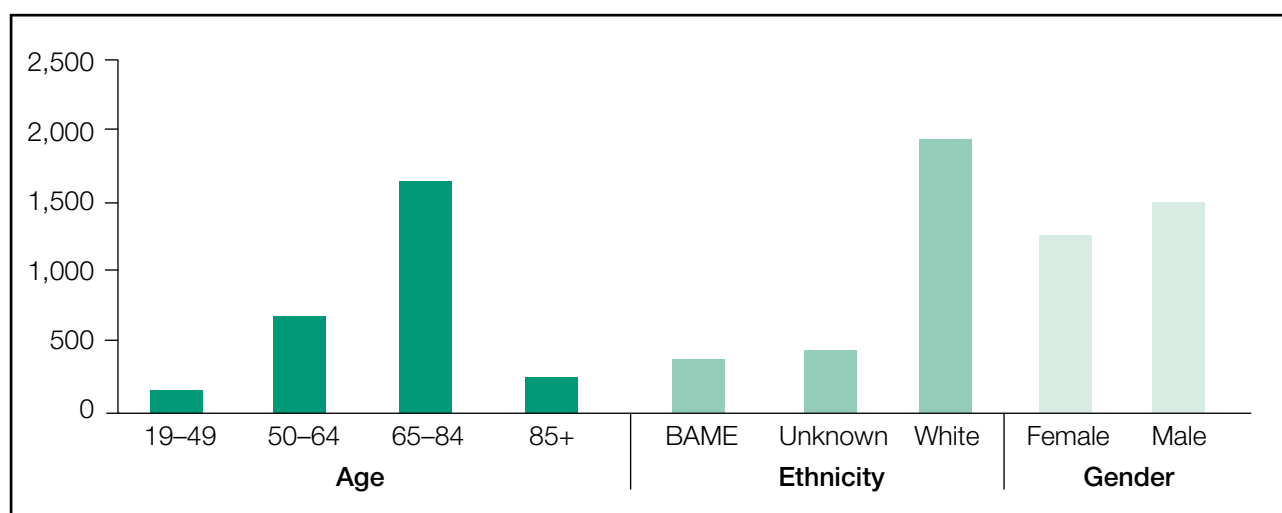
Hospital admissions

Hospital admissions and emergency hospital admissions for both asthma and COPD are significantly worse in Waltham Forest compared to England, London and London suburb averages. High hospital admission rates could be due to overall poor health of the population, poor management in primary and community care settings, or referral thresholds and practice particular to the local area. See INHALE profile online.

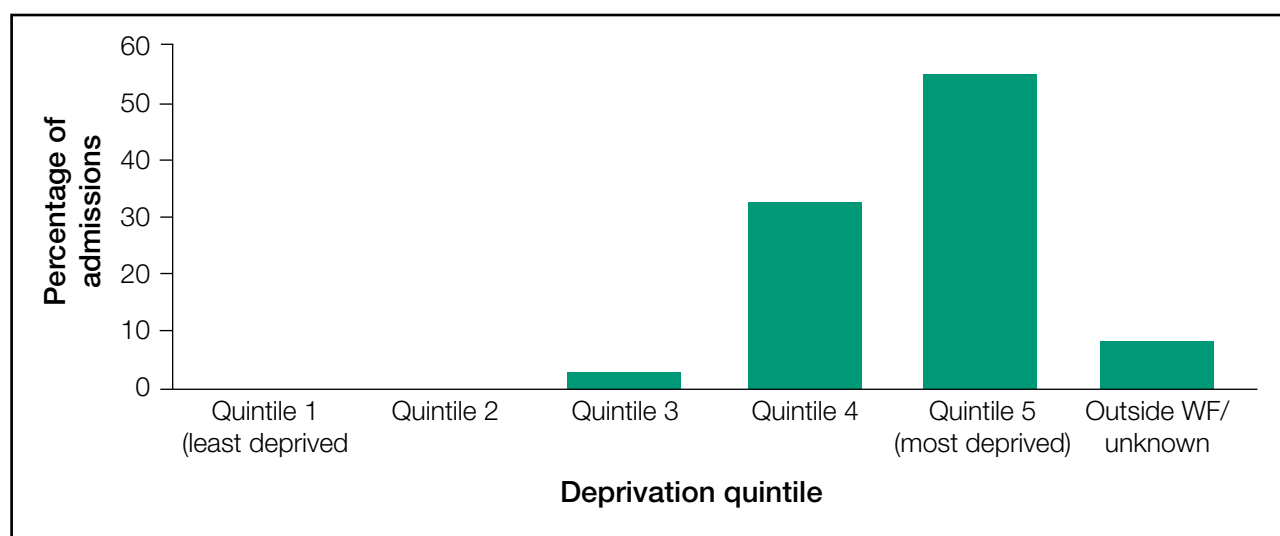
Health inequality

In 2012, an assessment of local data sources looked at cases of COPD by demographics. The results indicated that more cases were identified in people from White ethnic backgrounds compared with other ethnic backgrounds. Modelling suggests that the expected prevalence should be 3.36% for BAME population group in Waltham Forest³⁹⁴. The recorded prevalence is 0.3%, compared to a recorded prevalence of 1.3% for the White population who have a 4.26% expected prevalence. The difference in ratios of modelled to recorded prevalence suggests that diagnosis in BAME groups should be assessed for possible under-diagnosis. Expected and recorded prevalence has changed since this assessment took place and a refresh of this data is required.

Figure 6.23 Number of COPD cases in Waltham Forest, 2012



³⁹⁴ HNA Toolkit 2011.

Figure 6.24 Admissions 2011/12 by deprivation quintile

The highest proportion of patients admitted to hospital for COPD in 2011/12 lived in the most deprived areas of the borough.

Evidence of effective interventions

Prevention and early detection

Current and ex-smokers are most at risk of contracting COPD. People exposed to dust and gases in the work place are also at risk. The most effective intervention for preventing COPD is by not starting or stopping smoking, avoiding and controlling risks in the workplace.

Reducing smoking prevalence is one of the major health programmes in Waltham Forest. Evidence shows that educating young people to the dangers of smoking is an effective intervention to prevent taking up smoking. The government strategy to improve COPD outcomes identifies stigmatisation of lung disease as being 'self-inflicted' as a barrier to prevention and early detection activities. Health professionals and the public should work together to overcome this preconception. Better public awareness of lung disease can also improve early detection rates³⁹⁵.

Health care

A review of case studies of evidence-based best practice in quality and innovation showed that the most cost-effectiveness services are those that prevent patients from being admitted to hospital, provide services at or close to home, and address issues of anxiety through community-based care, and treat psychological conditions.

What is the public perspective?

The results of a patient survey conducted in 2008³⁹⁶ suggest that the phase leading to an emergency admission can be quite long, implying there are opportunities to intervene earlier to prevent hospital admissions in patients. Just over half (57%) of these patients stated that they sought advice from their GP, respiratory nurse or hospital doctor by phone. Most respondents (85%) knew what COPD meant and 79% knew that they already had it. Only a quarter (25%) had been given a written plan for what to do when their chest symptoms worsen. The respondents made the following suggestions for service improvement:

- More care and help at home
- Greater access to respiratory nurses.

³⁹⁵ An outcomes strategy for Chronic Obstructive Pulmonary Disease (COPD) and Asthma in England.

³⁹⁶ The National Chronic Obstructive Pulmonary Disease Audit 2008: Patient Survey.

What we are doing to address the issues

Prevention

Tobacco control and stop smoking services are key services in Waltham Forest. A recent analysis of smokers and service users identified that men have significantly lower rates of stopping compared to women, and compared to the national average for men. The local stop smoking service has undergone a service redesign to improve accessibility and quality of services. More work is needed to engage in high risk groups, reduce supply of cheap cigarettes and other tobacco products.

Health care

Primary and Secondary care services have worked together on a range of improvement projects since 2009. Since 2011, a project to improve COPD care across the pathway has operated in the borough. The objective of the project has been to integrate aspects of primary, community and acute care in order to improve COPD care in Waltham Forest and align it further toward NICE Gold Standard and COPD Outcomes Standard. These state (among others) that patients should have a positive experience of care, are helped to recover from episodes of ill-health, that their quality of life should be enhanced and that they should be prevented from dying prematurely.

Additional types of respiratory clinic have been introduced to the community pathway to achieve the improved management of patients with COPD in primary and community care. This also involves enabling patients to better self-manage their condition. The anticipated outcome of these clinics is reduced admissions to A&E by patients suffering an exacerbation.

Whipps Cross Hospital has introduced a 'discharge bundle'. This has five elements of care: a) the patient is offered a smoking cessation referral: b) inhaler technique is checked and (if necessary) corrected: c) a self-management plan is issued and checked that it is understood by the patient: d) a rescue pack is issued and the patient is instructed how to use it: e) a follow-up by the community respiratory team is planned prior to discharge.

This is supported by community post-discharge clinics which offer a follow-up appointment to the patient within two weeks. These clinics check the elements of the discharge bundle and assess the patient for pulmonary rehabilitation. It provides the patient with a face-to-face contact with the community respiratory team. They can be confident to use this service as their first point of call when they are next unwell with their COPD. Administration and communication between the community team and the hospital has been improved. Patients are now handed over on a daily basis between the Whipps Cross clinical team and nurse within the community respiratory team. Discharge summaries are now electronically transferred by e-mail rather than paper. Discharge summaries and communication with the patient is recorded on RiO.

Diagnostic spirometry clinics provide validated diagnoses of COPD to the NICE Quality Standard. These tests are conducted by health care assistants with oversight from a respiratory nurse. General practitioners can refer to these clinics.

What evidence is there where we are making a difference?

The following recommendations from previous JSNA's have been put into place:

- Provide a high quality, evidence-based package of early detection and care for all patients with asthma and COPD. In particular focus on COPD diagnosis using spirometry, ensuring smokers receive stop smoking support from NHS Stop Smoking Services, and provide all diagnosed COPD patient with Pulmonary Rehabilitation
- Embed new pathways including self-management
- Increase improvements in diagnostic spirometry and severity recording with community and prescribing support
- Reduce emergency admissions and readmissions with more effective use of community resources
- Redesign pulmonary rehab provision.

Progress will be assessed and evaluated to assess how well these recommendations are improving outcomes for local residents.

Priorities for the next five years

- Full implementation of the Waltham Forest Health and Wellbeing Strategy, Enterprise Employment and Skills Strategy, and Housing Strategy to reduce the number of people living with a life-limiting illness
- Invest in school-based programmes proven to prevent young people from taking up smoking that address the general school population and targeted interventions
- De-stigmatise lung disease to increase public engagement with early detection programmes and risk-limiting services for stopping smoking and increasing exercise
- Continue to improve, through primary care transformation, diagnosis and management of COPD in primary care to reduce the number of emergency admissions
- Provide high quality patient education and rehabilitation services that enable COPD patients to maintain good mental health, mobility, and reduce social isolation.

6.7 Ambulatory care sensitive conditions

An ambulatory care-sensitive condition (ACSC) is one where admission to hospital is potentially avoidable through good quality primary and preventive care. Most chronic conditions such as asthma, diabetes, and COPD are considered ACSCs. Detecting ACSCs early when there is a possibility of cure or of management in the community could delay not only hospital admissions but also mortality.

As well as treatment, ambulatory care also includes preventive measures such as screening and the management of risk factors such as cholesterol and blood pressure. When patients are admitted to hospital for treatment of an ACS condition, this can be thought of as an avoidable hospital admission or failure in primary care delivery. Rates of ACSC admissions are therefore often used as a measure of the quality of primary care in a local area.

The North East Public Health Observatory classified the ACSCs into three categories:

1. **Chronic conditions**, i.e. those long-term conditions for which rate of progression and incidence as acute episodes requiring hospital admission can be reduced by effective primary and community care (e.g. asthma, chronic obstructive pulmonary disease, congestive heart failure, angina, hypertension, diabetes, musculo-skeletal disorders such as rheumatoid arthritis, anaemia and nutritional deficiencies). Waltham Forest has higher unplanned admissions than London as shown in Table 6.23.

Table 6.23 Unplanned hospitalisation for chronic ambulatory care sensitive conditions

	Unplanned hospitalisation for chronic ambulatory care sensitive conditions, directly standardised rates (DSR) per 100,000	
	2010/11	2011/12
Waltham Forest	1,024	1,065
London	883	914

Source: Health and Social Care Information Centre.

2. **Acute aggravated conditions**, i.e., those where failure to provide timely and efficacious primary care interventions aggravate the condition and thus produce the need for hospital admission (e.g., cellulitis, convulsions and epilepsy, dental conditions, ear-nose-throat infections, gangrene, gastroenteritis, pelvic inflammatory disease, perforated/bleeding ulcer, pyelonephritis).
3. **Immunisable conditions** i.e., those where immunisation can prevent the onset of the condition and hence the need for a hospital admission (e.g., influenza, pertussis, rheumatic fever, tetanus and the range of conditions for which we usually provide population wide vaccination programmes)³⁹⁷.

The ambulatory care sensitive conditions discussed in the 2012/13 JSNA include diabetes and respiratory diseases chronic obstructive pulmonary disease and asthma.

³⁹⁷ Gray, A. 2009. Ambulatory Care Sensitive Conditions: a note for commissioners workshop 22/9/2009. North East Public Health Observatory.

7

Health protection

7.1 Seasonal influenza

Executive summary

Following the transition of public health to the local authority on 1 April 2013, local authorities, through their Director of Public Health, have responsibility for:

- providing appropriate challenge to local arrangements and advocacy with key stakeholders to ensure access to flu vaccination and to improve its uptake by eligible populations
- providing independent scrutiny and challenge to the arrangements of NHS England, PHE and local authority employers of frontline social care staff and other providers of health and social care
- providing leadership, together with local resilience partners to respond appropriately to local incidents and outbreaks of flu infection.

Influenza can be severe for children under six months of age, older people, pregnant women, and those with underlying disease, especially chronic respiratory, cardiac disease and immunosuppression.³⁹⁸

Influenza can place considerable yet unpredictable pressure on the NHS during the busy winter period. Much work has been undertaken locally to ensure a robust, evidence-based approach is taken to local multi-agency planning and implementation of the seasonal flu programme.

Recommendations

- Vaccination of patients at risk before the virus starts to circulate
- Vaccination of frontline health and social care staff
- Ensure hygiene and case management advice is circulated to community services, primary care and the local population
- Monitor local vaccine uptake in high risk patients and health and social care staff
- Work with North East and North Central London Health Protection Team (NENCL HPT) to monitor local flu activity and to manage outbreaks
- Ensure antiviral medicines are offered and available for patients in at risk groups for treatment of flu as per NICE guidelines
- Monitor impact of flu on NHS services locally and support acute and community services as winter pressures develop. Work with NHS England to ensure the acute care pathway remains viable in NE London.

³⁹⁸ Immunisation against infectious diseases, Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079917

What is seasonal flu?

Influenza is an acute viral infection of the respiratory tract transmitted by the aerosol, droplets or by direct contact with the respiratory secretions of someone with the infection.³⁹⁹ It is characterised by a sudden onset of fever, chills, headache, myalgia and extreme fatigue. Other symptoms include a dry cough, sore throat and runny nose. The illness is usually self-limiting and lasts between 2 and 7 days. It may be complicated by bronchitis, bacterial pneumonia, otitis media, meningitis, encephalitis or meningo-encephalitis. However, between 30 and 50% of infections may be asymptomatic.

There are three types of flu virus: A, B and C. Influenza A causes outbreaks most seasons and is usually responsible for epidemics. The influenza A virus can change gradually from year to year. Major changes in the virus result in a strain new to the population which can cause widespread and sometimes severe disease if there is little immunity to it⁴⁰⁰.

Public Health England, Department of Health and NHS England have developed a seasonal flu plan for winter 2013/14. This sets out the annual cycle of the seasonal flu programme and details all preparations to be undertaken locally including vaccine ordering (with contingencies for unexpected demand), robust plans for vaccine delivery to all in risk groups; communications to improve uptake and reporting mechanisms.

What is the local picture?

Influenza infection usually peaks during an 8 to 10 week period during the winter. The number of cases and severity can vary considerably from year to year depending on the strains of flu virus circulating and whether the general population have any immunity to these strains. The most severe flu season in the UK in the last 20 years occurred in 1999-2000. There were an estimated 21,497 excess winter deaths that year in England and Wales potentially attributable to flu.

The last flu pandemic was declared in 2009 caused by influenza A (H1N1) pdm09 virus. Whilst illness was widespread, for most the disease was mild and there were fewer than 500 confirmed deaths in the UK. Serious complications occurred predominately in people with underlying health conditions and pregnant women but a significant proportion arose in those who had been previously healthy. A high incidence of flu was seen in London early and throughout the pandemic. This is thought to have been due to the large and mobile nature of the population, with many people travelling into or through London each day.

During the 2012/13 season, the circulating strains were mainly Influenza A (H3N2) and Influenza B. Outbreaks were reported in schools, nurseries and other community settings in Waltham Forest as in all other areas of London.

What are effective interventions?

Influenza vaccination is an effective measure in preventing infection and outbreaks. WHO monitors the epidemiology of flu viruses in the world and how they are changing, making recommendations regarding the strains to be included in seasonal flu vaccine for the forthcoming season. This year for the 2013/14 northern hemisphere winter season, WHO recommend a trivalent vaccine containing:

- an A/California/7/2009 (H1N1) pdm09-like virus
- an A(H3N2) virus antigenically like the cell-propagated prototype virus A/Victoria/361/2011b
- a B/Massachusetts/2/2012-like virus.

It is recommended that quadrivalent vaccines containing two influenza B viruses contain the above three viruses and a B/Brisbane/60/2008-like virus.

³⁹⁹ Immunisation against infectious diseases, Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079917

⁴⁰⁰ Immunisation against infectious diseases, Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079917

The seasonal flu vaccine will be offered to those most at risk:

- All those aged 65 years or older
- All those aged six months or older in clinical risk groups (including pregnant women, see Green Book)
- Health and social care staff directly involved in the care of patients or clients
- Those living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality
- Those in receipt of a carer's allowance, or those who are the main carer of an elderly or disabled person whose welfare may be at risk if the carer falls ill
- Others involved directly in delivering health care such that they and vulnerable patients are at increased risk of exposure to seasonal influenza
- All those aged two and three-years-old.

For the 2013/14 season NHS England, Public Health England and Department of Health has set the target for seasonal influenza vaccine uptake at 75% for those over 65 years of age and 75% for those under 65 years and in risk groups⁴⁰¹. NHS NELC – Waltham Forest achieved coverage in the over 65 age group of 71.7% last year (London 71.2%).⁴⁰² Uptake in those under 65 years in high risk groups however was 48.7% (London 50.9%). Pregnant women were included in the seasonal influenza vaccine programme for the first time in 2010/11. Uptake in Waltham Forest was 27.2% (London 35.1%) amongst pregnant women.⁴⁰³

Uptake of seasonal flu vaccine amongst health care workers is poor. 37.8% of frontline health care workers in London were immunised last year against flu (England 45.6%) and only 47.5% of frontline staff in Waltham Forest.⁴⁰⁴ This is a slight improvement from previous years but there is still much to do. Vaccination of healthcare workers against flu significantly lowers rates of flu-like illness, hospitalisation and mortality in the elderly in healthcare settings. Staff immunisation may reduce transmission of infection to vulnerable patients in acute care, some of whom may have impaired immunity and who themselves may not be able to have the vaccine or produce an immune response to it.⁴⁰⁵

Outbreaks of influenza in high risk settings are reported to North East and North Central London Health Protection Team (NENCL HPT) which provides support and advice on case and incident management.

Public Health England (PHE) compiles UK flu surveillance information:

- Monitoring new consultations for influenza-like illness (ILI) from GP sentinel practices
- Virological surveillance (for laboratory confirmation and strain typing)
- PHE data on confirmed influenza infection where influenza contributed to death.

The local HPT provides local epidemiology to support outbreak management.

⁴⁰¹ CMO letter May 2012. Gateway number: 17488.

⁴⁰² Health and Social Care Information Centre (HSCIC) – 2012/13.

⁴⁰³ Seasonal Flu data for GPs, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203238/SeasonalFluData_GPs_Jan13_acc.pdf

⁴⁰⁴ Seasonal Influenza Uptake amongst Health Care Workers – Public Health England 2012/13 – https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/245605/Seasonal_Influenza_Vaccine_Uptake_HCWs_2012_13.pdf

⁴⁰⁵ CMO letter May 2011. Seasonal flu immunisation programme 2011/12.

What is being done locally to address low vaccine uptake?

The DH seasonal flu plan, 2013/14 contains an updated good practice guide for GPs to assist them with increasing uptake of flu vaccine in high risk groups locally. There is a growing published evidence base which illustrates the contributory factors for success in primary care where high uptake rates are achieved. This focuses on up-to-date practice registers of high risk individuals, robust call and recall systems and efficient data collection. Consideration will continue to be given to improving access arrangements e.g. evening and weekend clinics.

Work will continue with acute trust and community Occupational Health providers, supported by North East and North Central London Health Protection Team (NENCL HPT), to improve uptake amongst health care workers (HCWs). Education sessions are planned for social care staff to improve staff vaccine uptake and also case and outbreak management in the local community.

What are the priorities for improvement over next five years?

It is important that the seasonal flu programme is supported and improved as new structures and organisations come into existence. It is vital that new roles and responsibilities are understood. The public health team in Waltham Forest is working hard to ensure consistency of planning and implementation of the seasonal flu programme across North East London.

Next season (2014/15) a universal programme of influenza vaccination is planned for 4 to 10-year-olds across England. Depending upon results from pilot sites this season, this is likely to be a schools-based programme.

7.2 Sexual and reproductive health

Executive summary

Sexual health is influenced by a number of factors including sexual behaviour and attitudes. Unprotected sex, sometimes influenced by excessive drug and alcohol use are risk factors for sexual ill health.

STIs

Rates of STIs have been increasing nationally and in London. Waltham Forest rate is similar to the London average and almost double the England average. Waltham Forest is ranked 15th in England (out of 326 local authorities, first in the rank has highest rates) for rates of STIs in 2012. The highest rates of STIs in Waltham Forest continue to be in Chlamydia, with the lowest rates in Syphilis.

Young people are disproportionately affected by STIs. 47% diagnosed acute STIs in Waltham Forest in 2011 were in young people aged 15 to 24-years-old.

HIV

The prevalence of diagnosed HIV in Waltham Forest in 2011 was 4.4 per 1,000 aged 15 to 59. The London average was 5.4. The highest rates are found in the south and centre of the borough. Waltham Forest ranked 18th highest out of 33 London boroughs for HIV prevalence in 2011.

In terms of numbers, there were 433 people aged 15 to 59 years living with HIV in Waltham Forest in 2002. By 2010 this had risen to 753, an increase of 74%. In 2011, 802 Waltham Forest residents accessed HIV-related care.

The age profile of people diagnosed with HIV is different from that of STIs. Nearly half of those diagnosed with STIs in Waltham Forest are aged under 25; compared with only 5% of those diagnosed with HIV aged under 25. People with HIV now live longer and this has implications for social care.

In 2011, 47% of Waltham Forest residents diagnosed with HIV were late diagnoses. This is higher than the London average of 44%. Waltham Forest ranks 17th highest in London; but has lower rates than its statistical neighbours (Greenwich 58%, Croydon and Enfield 53% each).

Teenage pregnancy

There has been reduction in the number of teenage (under 18) pregnancies in Waltham Forest – from 206 conceptions in 1998 to 140 in 2011. The quarterly rate declined from 70.4 conceptions per 1,000 in March 1998 to 41.7 in March 2012. The London average in March 2012 was 29.3 per 1,000. The highest teenage pregnancy rates are found in Higham Hill, Lea Bridge, Cathall and Leyton.

Contraception

In terms of cost, GP prescribing of all the different methods of LARC (Long Acting Reversible Contraception) in Waltham Forest is low compared to our statistical neighbours, the London and England averages. This should be read with caution as the different methods have different costs.

There are no reliable data on EHC(Emergency Hormonal Contraception) activity in community pharmacies prior to April 2013. For the four months April – July 2013, a total of 1,430 free EHC were dispensed by the pharmacies. Young people aged up to 25 accounted for 823 (58%) of the total.

Current service provision

Delivery of sexual and reproductive health services in Waltham Forest occurs in primary care, secondary care and community services. The main service areas are:

- Genito-urinary medicine (GUM)
- Family planning/contraception
- Chlamydia screening
- HIV prevention
- Care and support for people affected by HIV.

Recommendations

- Develop an integrated sexual health service (combining GUM and contraception) in a hub and spoke model
- Combine the three community HIV prevention and care services into one service for procurement
- Work towards embedding the Chlamydia screening service in the integrated sexual health service when it is commissioned
- Re-commissioning of sexual and reproductive health services should include provision for comprehensive health promotion/prevention
- Explore the establishment of a holistic 'one stop shop' for young people providing a number of services (such as careers advice, sexual health and contraception, mental health and substance misuse) supported by effective outreach. This will reduce stigma associated with sexual health/mental health services
- Integrate SRE (Sex and Relationships Education) work into the Council's strategic work with schools via education department and work with schools to ensure SRE is not a 'one-off event'
- Work with GPs, GUM and SRH clinicians to agree the best model of psychosexual counselling provision. Benchmark provision in other areas
- Include a requirement in provider contracts to ensure information on their website is up to date and linked to stakeholder sites; and monitor as part of contract monitoring
- Ensure service specifications cover relevant NICE guidance, e.g. Hepatitis C testing in GUM clinics
- The Local Authority and CCG should agree responsibility for and funding mechanism for sexual health training (e.g. STIF, LARC, SHIP) for non-specialists and encourage attendance
- Work with relevant partners (e.g. CCG) to develop a coordinated response to tackling child sexual exploitation, 'sexually harmful' behaviours among young people and other forms of sexual violence
- Explore the necessity of undertaking a needs assessment of street sex workers in the borough to ascertain the need for services for this group. This would be better commissioned from an independent organisation.

What is sexual health?

According to the World Health Organisation:

*'Sexual health is a state of physical, mental and social wellbeing in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.'*⁴⁰⁶

⁴⁰⁶ http://www.who.int/topics/sexual_health/en/

Sexual health is influenced by a number of factors including sexual behaviour and attitudes. Sexual ill-health includes the problems of sexually transmitted infections (STIs) and human immunodeficiency virus (HIV), unintended pregnancy and abortion, and infertility, among others.

STIs and HIV are a significant public health concern; and can cause a range of illnesses which may lead to premature death. Unwanted pregnancy has a significant impact on individuals, especially girls; and termination can have long-term physical and psychological effects, leading to further health problems in the future. Teenage pregnancy often leads to poor health and social outcomes for the mother and baby.

Risk factors

- Unprotected sex is the major risk factor for the transmission of STIs. Risky behaviours such as frequent or excessive alcohol and drug use are associated with unprotected sex
- Increase locally in incidents of sexually harmful behaviours amongst young people
- In the UK those at higher risk of unprotected sex and STIs are young people, men who have sex with men (MSM), especially those over 35, and black Africans
- Teenage conceptions are often associated with high levels of deprivation
- Injecting drug users are also at high-risk for some STIs and HIV, through the sharing of needles.

Sexual health commissioning

The commissioning responsibilities of sexual health services moved in April 2013. Local authorities are now required to commission open-access sexual health (STI and contraception) services that meet the needs of their local population, determined through their Joint Strategic Needs Assessments. All contracts covering these services have been transferred to local authorities. Table 1 shows the new commissioning arrangements.

Sexual health services in Waltham Forest account for about 41% of the Public Health budget transferred to the local authority. This may seem a significant proportion of the public health budget but there has been under investment historically (compared to other London boroughs) within a context of high sexual and reproductive health need. The contracts have been extended as they were in 2012/13 and this review will help the local authority develop a commissioning plan for the future.

A major risk to sexual and reproductive health services for commissioners is the open access Genito-urinary Medicine (GUM) services, which means Waltham Forest residents can attend any GUM clinic in the country and the Local Authority will be billed. This makes it challenging to budget for.

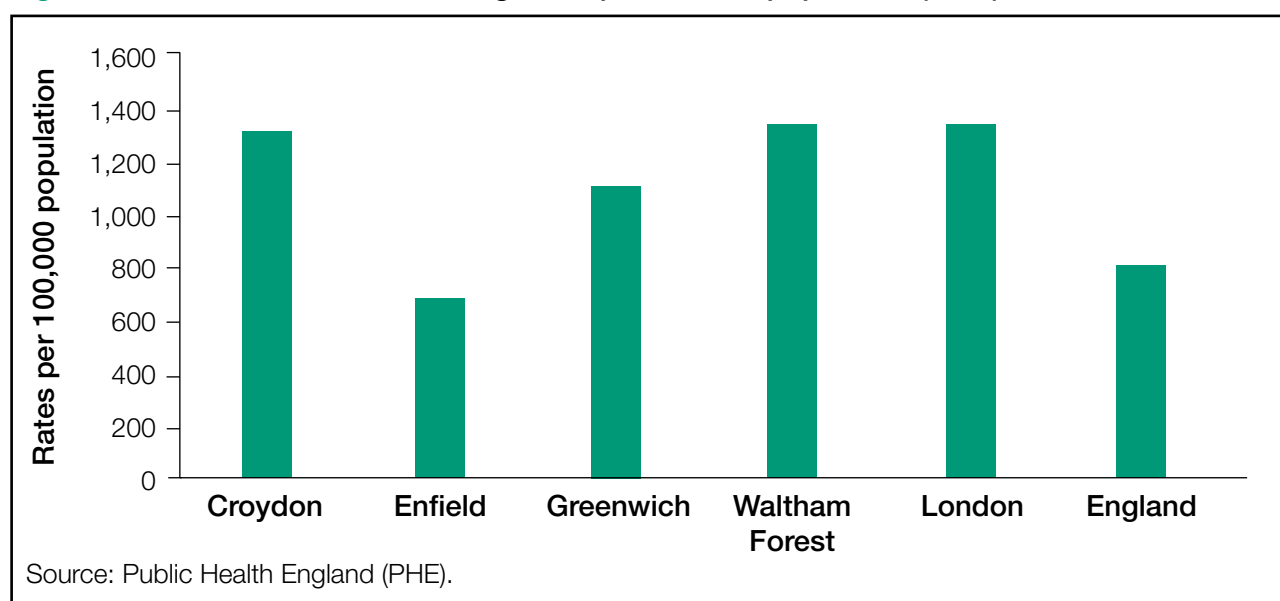
Not having a dedicated young people's service may influence young people to use services in other boroughs.

A significant proportion of Waltham Forest residents opt to use GUM services out of the borough. This is due in part to convenience, better quality, more user friendly and accessible services in those boroughs, for example Hackney. Due to market forces factor, attendance at clinics in inner London locations costs more than in Waltham Forest. This means we spend more when our residents go to clinics out of borough.

Local picture

Sexually Transmitted Infections (STIs)

Rates of STIs have been increasing nationally and in London. Figure 1 shows rates of acute STI diagnoses in Waltham Forest compared with London, England and our statistical neighbours (boroughs that have similar socio-demographic profiles). Waltham Forest rate is similar to Croydon and the London average but higher than Enfield, Greenwich and almost double the England average.

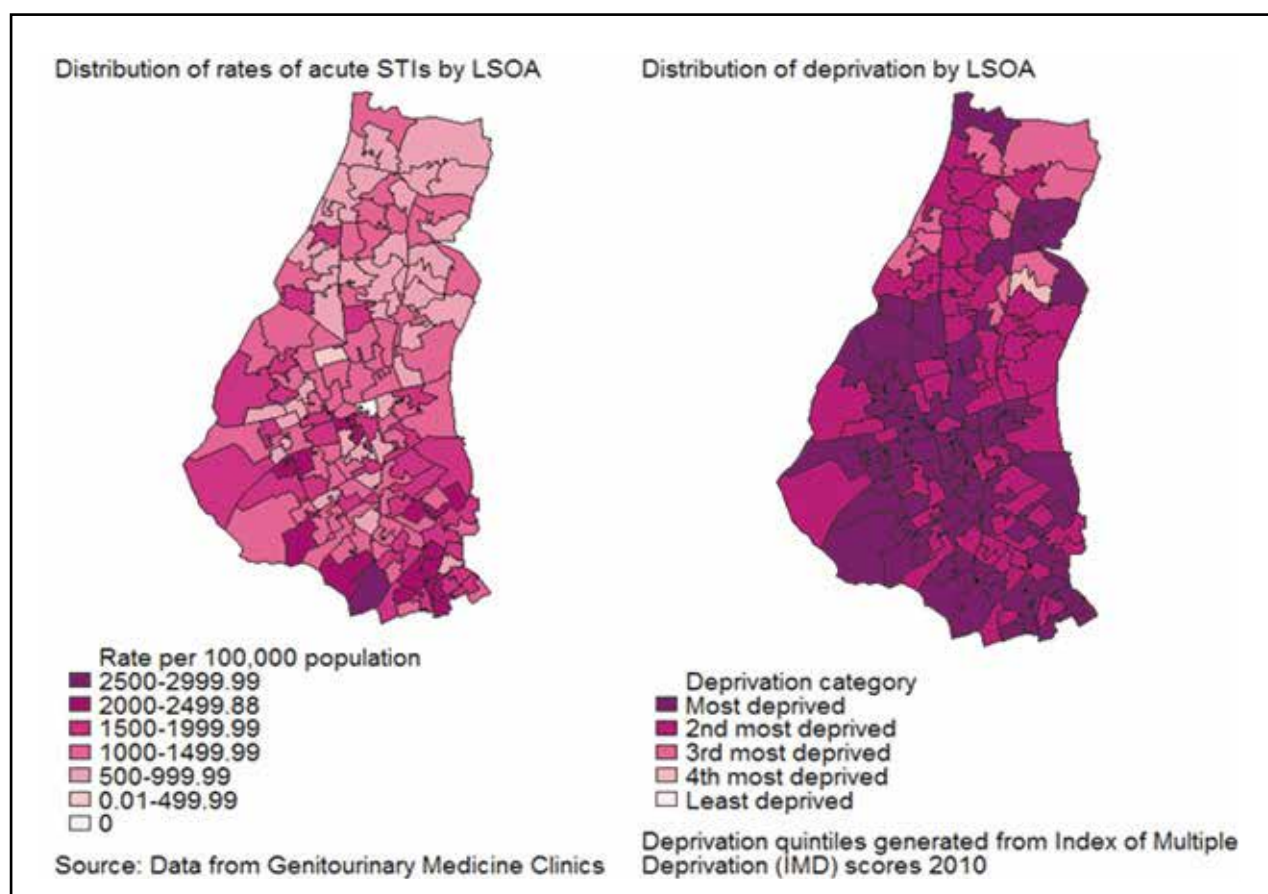
Figure 7.1 Rates of acute STI diagnoses per 100,000 population (2012)

In 2012 there were 1,342 acute STI diagnoses per 100,000 population in Waltham Forest, compared to an average of 1,337 in London and 804 in England⁴⁰⁷.

Waltham Forest is ranked 15th (out of 326 local authorities, first in the rank has highest rates) in England for rates of STIs in 2012. The highest rates of STIs in Waltham Forest continue to be in Chlamydia, with the lowest rates in Syphilis.

There is considerable geographic variation in the distribution of STIs in the borough; and some correlation with deprivation. Areas of high deprivation tend to have higher rates of STIs compared to areas of low deprivation. This is highlighted in Figure 7.2.

⁴⁰⁷ Public Health England (2013) Number and rates of acute STI diagnoses in England, 2009–12.

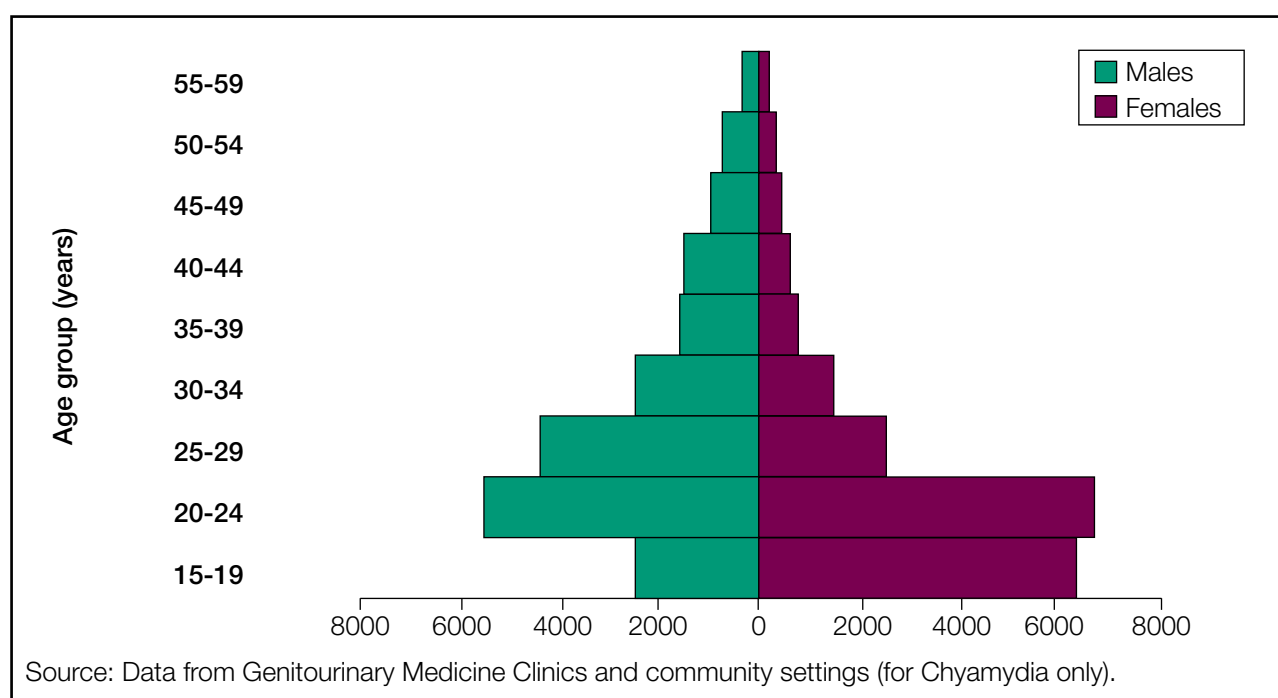
Figure 7.2 The rate per 100,000 of acute STIs by LSOA* in Waltham Forest: 2011

*Lower Layer Super Output Areas (LSOA) are built from groups of contiguous Output Areas and have been automatically generated to be as consistent in population size as possible, and typically contain from four to six Output Areas. The minimum population is 1,000 and the mean is 1,500.

Age and gender

47% diagnosed acute STIs in Waltham Forest in 2011 were in young people aged 15 to 24-years-old. Young people are also more likely to become reinfected with STIs. In Waltham Forest, an estimated 17.9% of 16 to 19-year-old women and 13.1% of 16 to 19-year-old men presenting with an acute STI at a GUM clinic during the three year period from 2009 to 2011 became reinfected with an STI within twelve months. This presents a challenge in terms of health promotion and prevention work.

Figure 7.3 describes STI diagnoses by age and gender, showing a higher burden among younger age groups for both males and females.

Figure 7.3 STI diagnosis in Waltham Forest residents

HIV

The prevalence of diagnosed HIV in Waltham Forest in 2011 was 4.4 per 1,000 aged 15 to 59. The London average was 5.4. The highest rates are found in the south and centre of the borough.

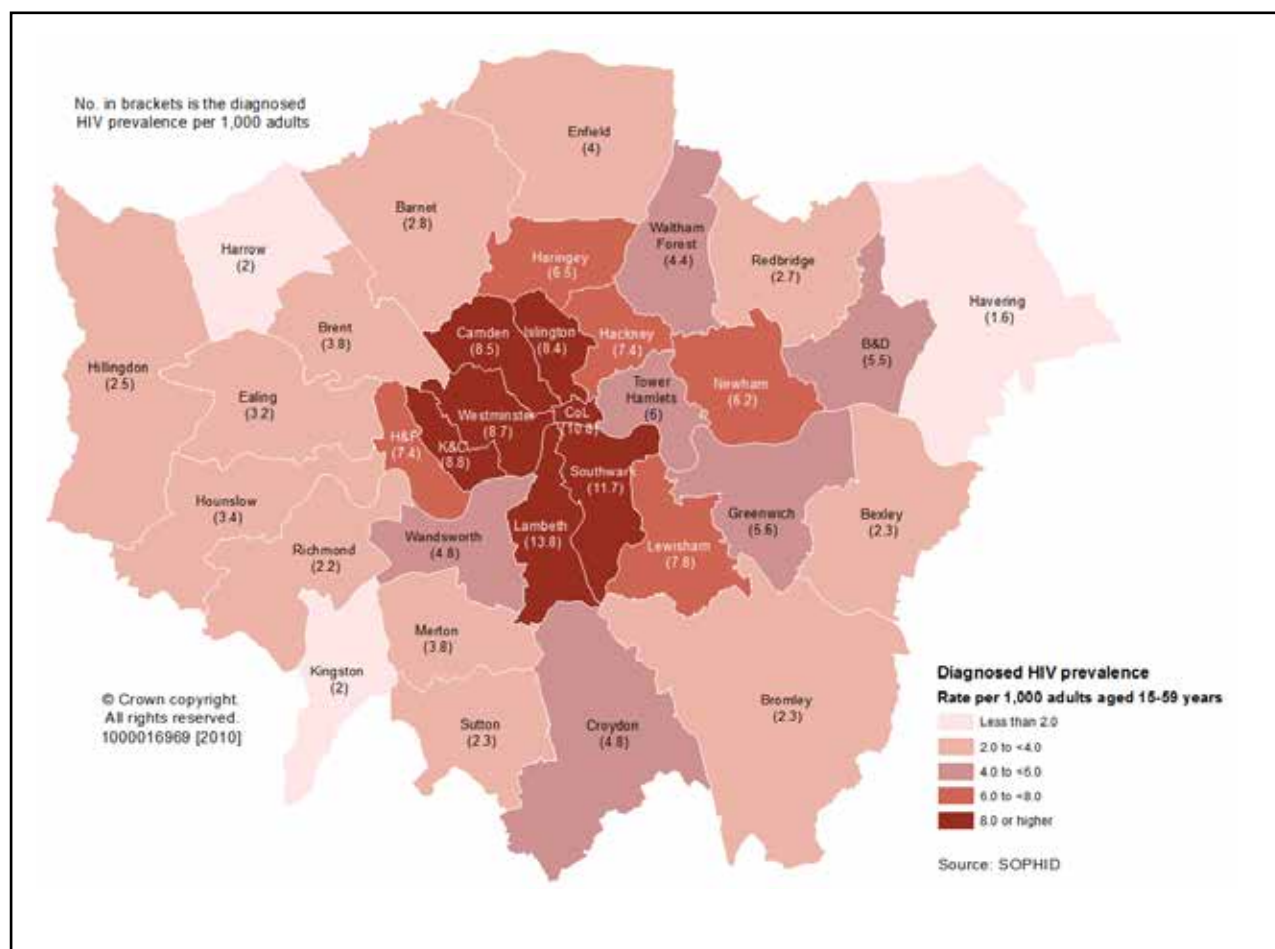
National HIV testing guidelines recommend offering HIV test to all new patients between the ages of 15 and 59 registering with GPs and all patients in medical admission units in areas of high HIV prevalence (above 2 per 1,000). Waltham Forest falls in this category and yet this is not currently offered. This presents a risk of onward transmission for people who may not be aware that they have the virus.

In terms of numbers, there were 433 people aged 15 to 59 years living with HIV in Waltham Forest in 2002. By 2010 this had risen to 753, an increase of 74%. In 2011, 802 Waltham Forest residents accessed HIV related care.

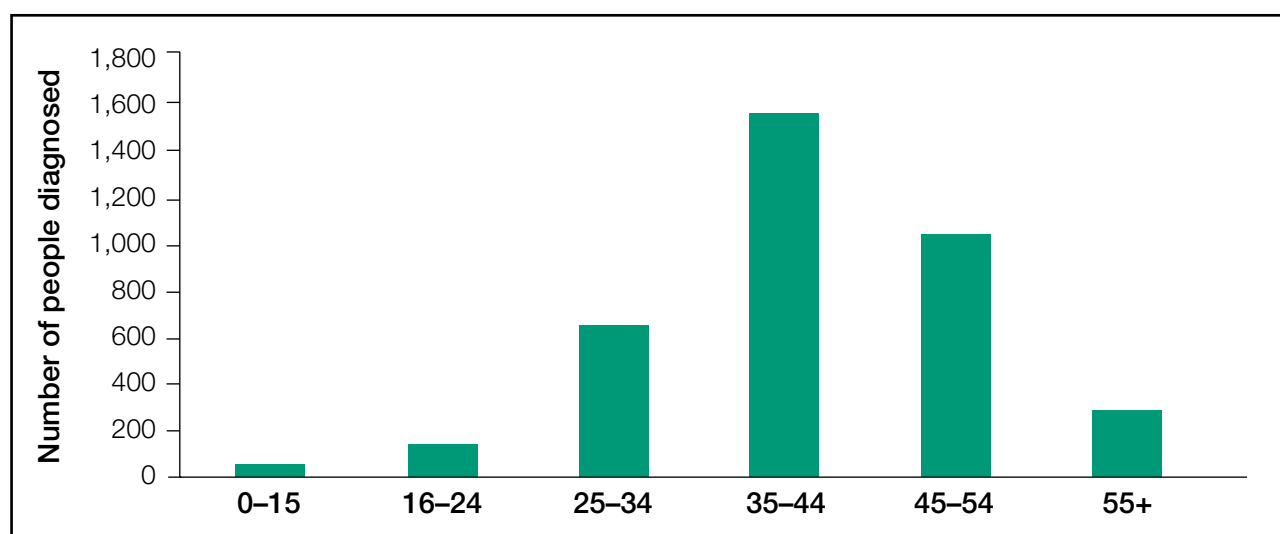
Waltham Forest ranked 18th highest out of 33 London boroughs for HIV prevalence in 2011. Figure 7.4 shows prevalence of diagnosed HIV in London by borough. Inner London boroughs tend to have higher prevalence than the outer London boroughs.

Compared to statistical neighbours, Waltham Forest's prevalence is similar to Enfield but lower than Croydon and Greenwich.

Figure 7.4 Prevalence of diagnosed HIV in London residents aged 15–59 years by Local Authority, 2011



The age profile of people diagnosed with HIV (Figure 7.5) is different from that of STIs. As mentioned above, nearly half of those diagnosed with STIs in Waltham Forest are aged under 25; compared with only 5% of those diagnosed with HIV aged under 25. People with HIV now live longer and this has implications for social care.

Figure 7.5 Age profile of people diagnosed with HIV in Waltham Forest (2007–11)

HIV route of infection

Heterosexual sex is the largest route of infection of HIV among Waltham Forest residents, accounting for 51% of all infections in 2011, followed by sex between men (43%). This compares to London average of 47% for sex between men and 46% for sex between men and women.

People of White ethnicity accounted for 44% of Waltham Forest residents accessing HIV care, followed by 36% black African. It is significant to note that black Africans constitute only 7.2% of the population of Waltham Forest but represent such a high proportion of people accessing HIV care. This presents a challenge for targeted HIV prevention work.

Late diagnosis is a problem in outer north east London, where all the Local Authorities have higher percentages of late diagnoses compared to England. Late diagnosis is now defined as having a CD4 count of less than 350/mm³ within three months of diagnosis.

In 2011, 47% of Waltham Forest residents diagnosed with HIV were late diagnoses. This is higher than the London average of 44%. Waltham Forest ranks 17th highest in London; but has lower rates than its statistical neighbours (Greenwich 58%, Croydon and Enfield 53% each).

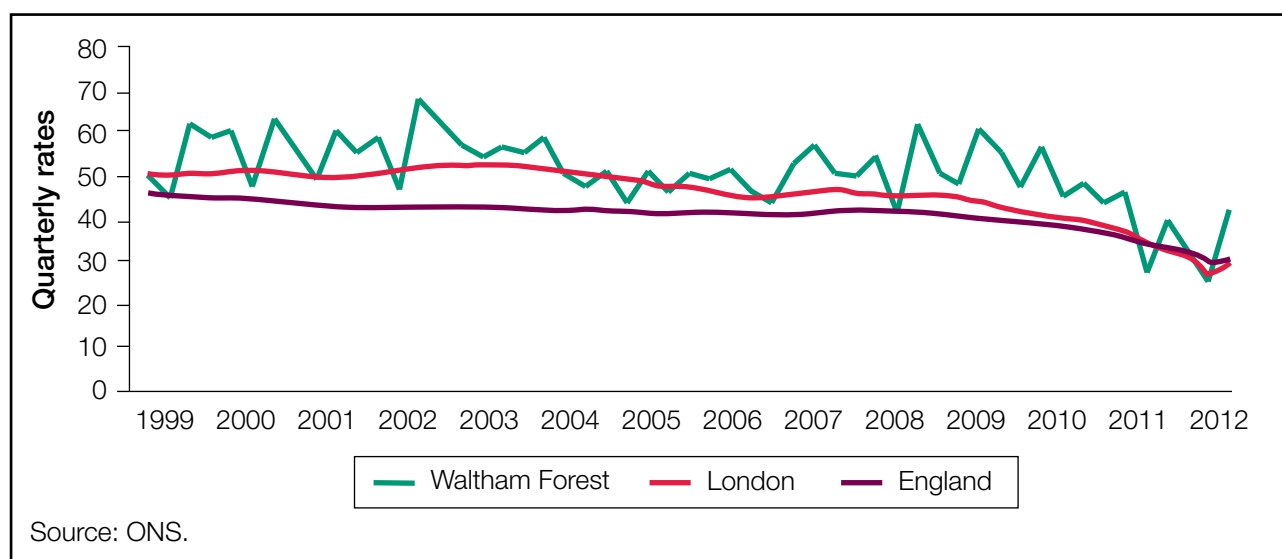
Late diagnosis of HIV infection results in significantly increased morbidity and early mortality, as well as the risk of unknowingly transmitting infection, all of which are preventable. It is also more costly in terms of treatment and hospital stay.

Addressing secondary prevention is important in tackling high HIV prevalence. A stable patient is less likely to pass on infection due to low viral loads. Biomedical interventions therefore need to be integrated with wellbeing and social care interventions. Social care should include information, advice, advocacy and mental health wellbeing support.

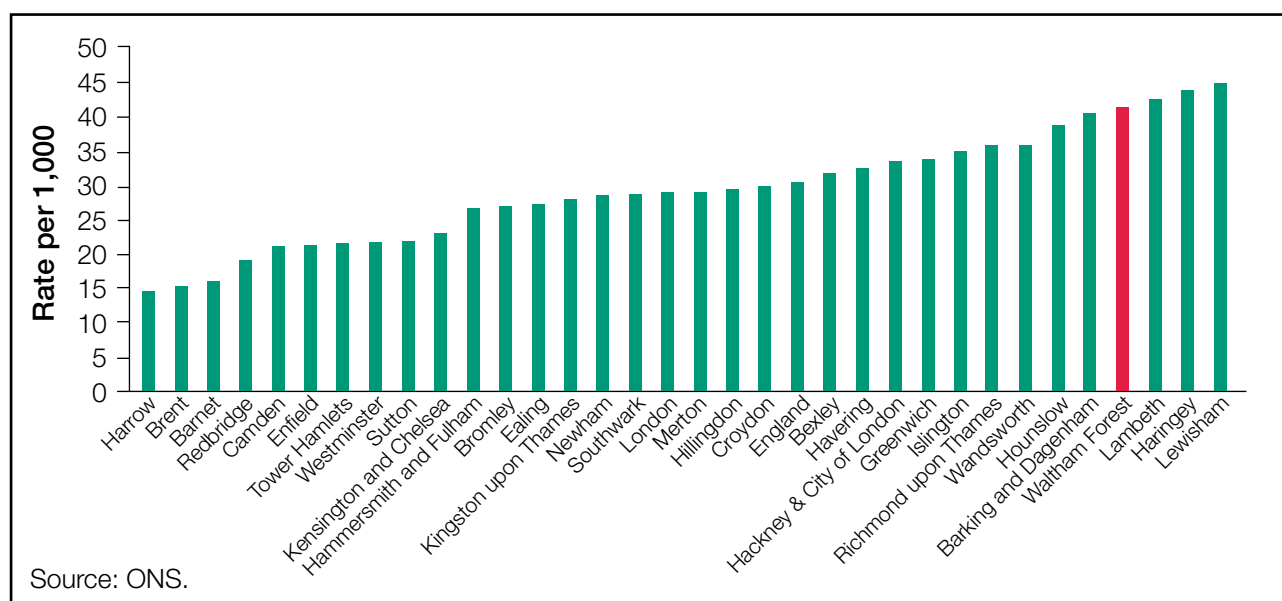
Teenage pregnancy

There has been reduction in the number of teenage (under 18) pregnancies in Waltham Forest – from 206 conceptions in 1998 to 140 in 2011. The quarterly rate declined from 70.4 conceptions per 1,000 in March 1998 to 41.7 in March 2012 although figures fluctuate from year to year. The London average in March 2012 was 29.3 per 1,000.

Figure 7.6 sets out trends in teenage pregnancy rates in Waltham Forest, London and England, showing a general decline from the 1998 rate.

Figure 7.6 Trends in teenage pregnancy rates (per 1,000 females ages 15 to 17)

The latest published quarterly rates are for March 2012, which shows that Waltham Forest's rate is above London, England and our statistical comparators (see Figure 7.7).

Figure 7.7 Teenage pregnancy rates, March 2012

Due to small numbers, ward level teenage conception rates are generally published by combining three years' data. Four wards in Waltham Forest were among the 20% of wards in England with the highest rates (at least 53.1 conceptions per 1,000 women aged 15 to 17) in 2006–08. They are Higham Hill, Lea Bridge, Cathall and Leyton.

Teenage abortions

In 2011 Waltham Forest had 141 abortions in women aged under 19, of which 26 (18%) were repeat abortions. This is higher than the 11% and 16% repeat abortion rates for under 19s in England and London respectively.

In 2011/12 the main abortion service provider for Waltham Forest residents performed 1,620 abortions in total, less than the 1,793 performed the previous year. Five per cent (87) were for under 18s, also less than the 8% under 18s the previous year. This suggests that both teenage pregnancies and abortions are declining in Waltham Forest.

Contraception

There are different methods of contraception, which are all available at family planning clinics. Most of them are available from GP practices. Emergency Hormonal Contraception (EHC, morning after pill) is available for free in selected pharmacies in Waltham Forest. This is funded by the Council as part of its sexual and reproductive health offer. See appendix 5 for a list of pharmacies providing this service).

Long Acting Reversible Contraception (LARC) is the most effective method and does not depend on a woman remembering to take or use it. NICE recommends increasing uptake of LARC and primary care is a very accessible setting to achieve this. In terms of cost, GP prescribing of LARC in Waltham Forest is low compared to our statistical neighbours, the London and England averages, as shown in Figure 7.8. This should be read with caution as the different methods have different costs.

Figure 7.8 Rate, cost of GP prescribed long-acting reversible contraception (LARC), 2011/12

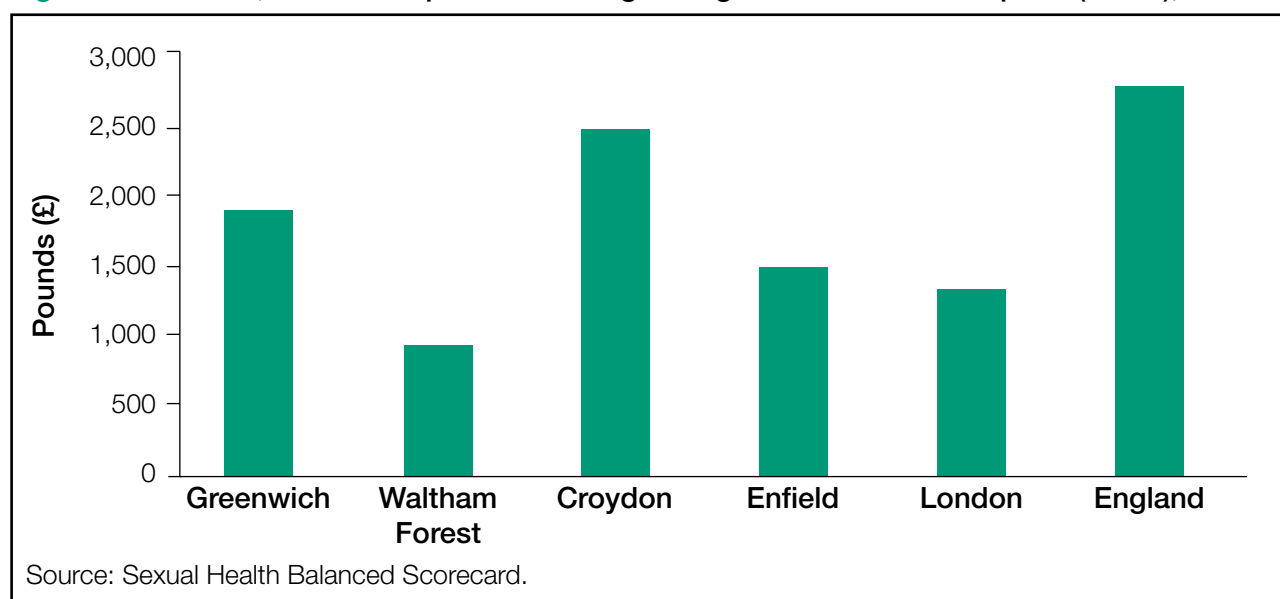


Figure 7.9 sets out the GP prescribing costs of the individual LARC methods. Waltham Forest spent relatively low in all methods.

Figure 7.9 Cost of GP prescribed LARC methods, 2011/12

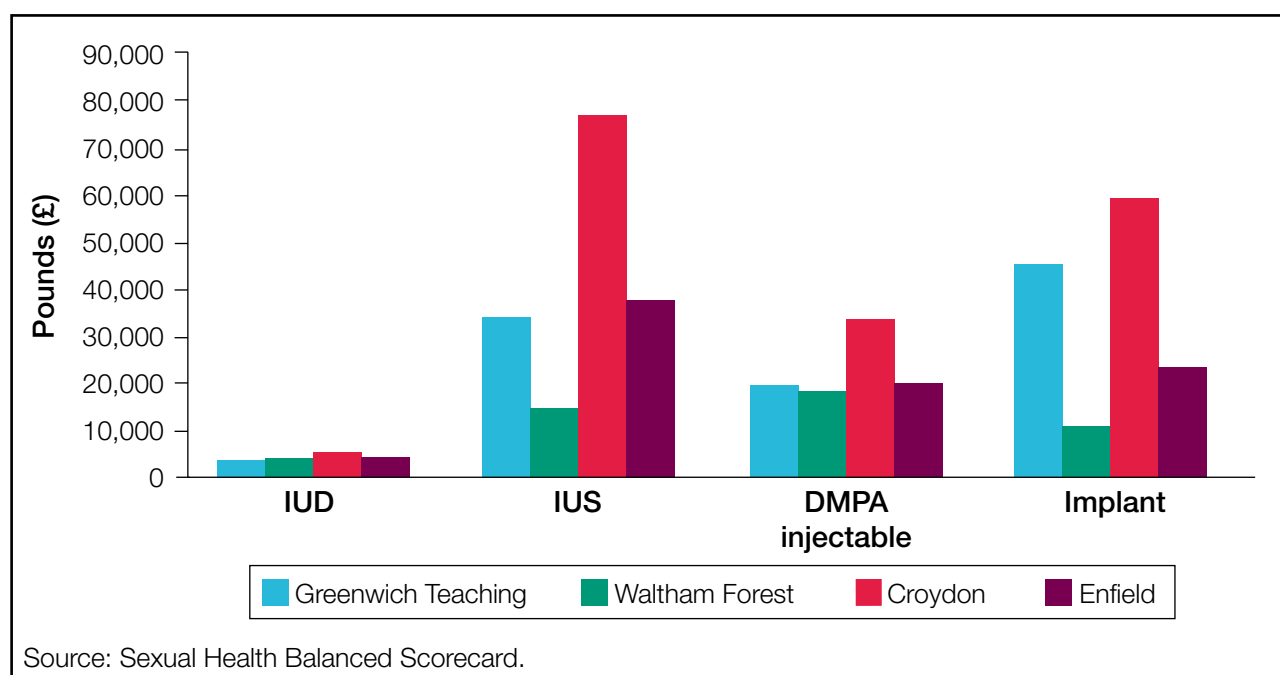
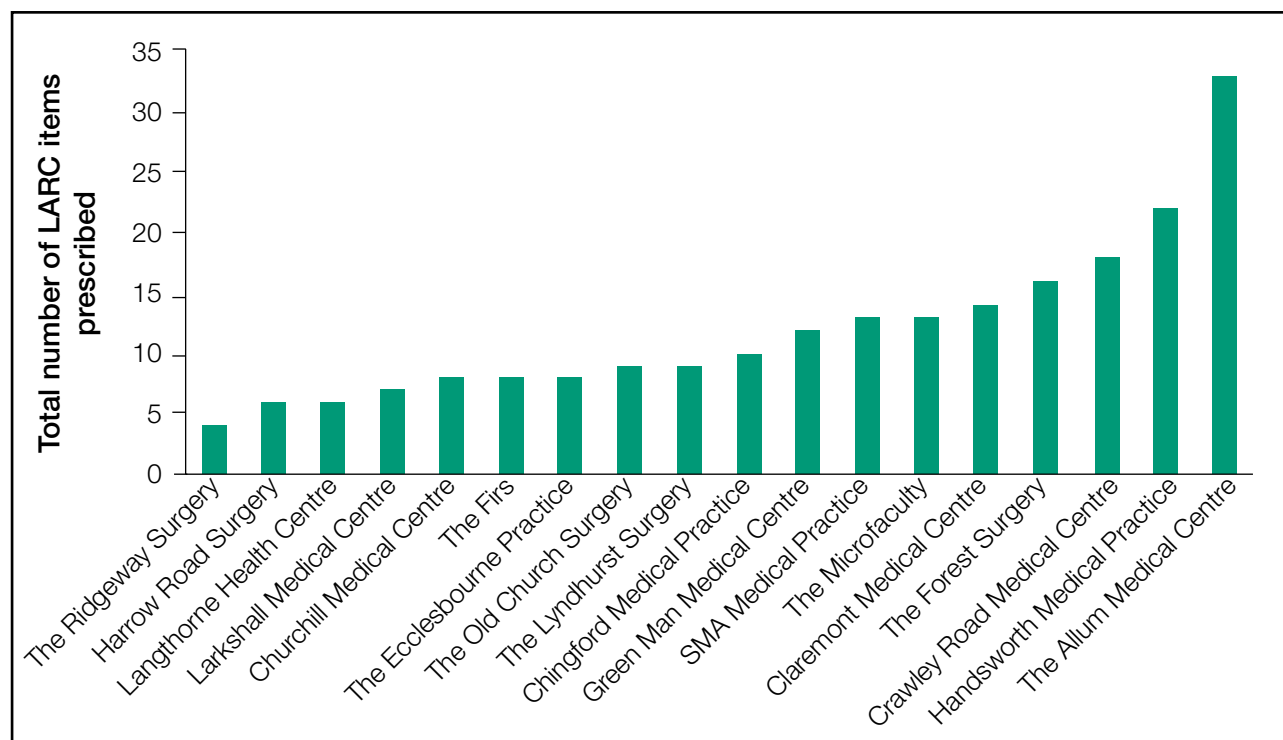


Figure 7.10 shows the practices that prescribed LARC during 2012/13 and the number of items prescribed. Only 18 out of 45 practices prescribed LARC during the year. Due to data access issues it is not possible to obtain practice level data in other boroughs for comparison.

Figure 7.10 LARC devices prescribed by Waltham Forest Practices in 2012/13



Only three of these practices (The Firs, Forest Surgery and Claremont Medical Centre) are located in Walthamstow locality – seven in Chingford and eight in Leyton/Leytonstone. Given that Walthamstow locality has the highest population (43% of the borough's population) among the three localities, and the main family planning clinic is located in Leyton, there is a case for LARC provision in the Walthamstow area. For example, Lea Bridge ward in Walthamstow has one of the highest teenage pregnancy rates but there is no GP practice providing LARC or family planning clinic within the ward.

Sex workers

There are anecdotal reports of street sex workers operating in the borough. The substance misuse services have been in contact with women who later on report that they are street sex workers. Those women are signposted to the Blood Borne Virus service and the Department of Sexual Health at Whipps Cross Hospital.

Between 2 and 7 of the clients they assess annually report that they are street sex workers. However, the services believe that this is a gross under estimate as clients are often reluctant to disclose that they are sex workers. The substance misuse outreach workers see far more street sex workers during night time outreach work. However, there are no data to estimate the size of the issue or level of need. This means there is no information to establish whether or not the current services meet the needs of this vulnerable group. More work is needed to identify the need of this group. Assessing local need might involve triangulating data from police, substance misuse services, homeless services and possibly services in neighbouring boroughs.

Sexually harmful behaviours

Harmful sexual behaviour involves one or more children engaging in sexual discussions or acts that are inappropriate for their age or stage of development. These can range from using sexually explicit words and phrases to full penetrative sex with other children or adults.

There are reports of a number of exclusions from schools in Waltham Forest as a result of 'sexually harmful' behaviours. The data from schools are for sexual misconduct, which is an imperfect match with the definition of sexually problematic and harmful behaviour. It is very much at the school's discretion what they categorise as sexual misconduct – it could, therefore, cover incidents on a continuum from inappropriate touching up to sexual assault.

There are relatively few convictions for sexual assaults within the Youth Offending Service. The much larger problem relates to non-convicted behaviours such as inappropriate touching in schools. These behaviours are often related to gangs and substance misuse. There are no accurate figures to estimate the scale of the problem and the Council is recruiting a project manager whose role, among others, would be to help clarify this.

In the meantime Head Teachers have commissioned a piece of work to promote training in assessing and managing these behaviours in schools.

With the changes in commissioning responsibility, the Local Authority and CCG need to develop a co-ordinated response to tackling these issues as part of tackling sexual violence, including FGM. This could be set within the context of the Violence Against Women and Girls (VAWG) agenda. As NHS England commissions specialist sexual assault services nationally, it would be worth liaising with them.

What are effective interventions?

The benefits of preventing an STI extend beyond the individual as onward transmission to other people is also prevented. The following interventions (Table 7.1) have been found to improve sexual health. These are based on NICE guidance^{408, 409, 410, 411}, research commissioned by Department of Health and other national policy documents on sexual health.

Table 7.1 Evidence base for effective sexual health interventions

Work area	Interventions
Contraception and abortion services	<ul style="list-style-type: none"> Increasing uptake of Long Acting Reversible Contraception (LARC) Promoting access to services that provide information and choice on the full range of contraceptive methods Improve access, remove barriers and have clear pathways to reduce delays in obtaining abortion Offering contraception and follow up post termination of pregnancy.
Screening	<p>Screening strategies targeting high risk populations such as pregnant women for HIV and young women for Chlamydia are cost saving, leading to early treatment, averting cost of complications (such as infertility) and onward transmission. Cost saving measures include:</p> <ul style="list-style-type: none"> Antenatal screening for HIV in high-risk women Antenatal syphilis screening Chlamydia screening for young people and groups at high risk Routine opt out HIV testing in GP practices and outpatients.

⁴⁰⁸ NICE (2005) Long acting reversible contraception. Clinical guideline.

⁴⁰⁹ NICE (2011) Increasing the uptake of HIV testing among black African in England.

⁴¹⁰ BICE (2011) Increasing the uptake of HIV testing among men who have sex with men.

⁴¹¹ NICE (2007) Prevention of sexually transmitted infections and under-18 conceptions.

Work area	Interventions
Treatment interventions and service organisations/ delivery for STIs and HIV	<p>Comprehensive and accessible STI treatment services are cost saving; and partner notification and highly active antiretroviral therapy (HAART) are cost effective. Measures include:</p> <ul style="list-style-type: none"> • STI treatment services in groups at high risk • Partner notification • Access to services with very short/no waiting times • Antiretroviral treatment for HIV • Routine HIV testing for STI clinic attendees • Reduce late and undiagnosed HIV through the provision of testing in a range of settings • Improve understanding and awareness of barriers to HIV testing particularly in affected communities • Reduce HIV-related stigma • Ensure integrated HIV service to meet the needs of those living with HIV/ AIDS.
Health promotion and disease prevention	<p>A range of interventions aimed at preventing HIV and promoting sexual health are cost-saving and are most cost-effective when targeted at high-risk groups. For example for every £1 spent on contraceptive services, the net gain to the NHS has been estimated to be £11.</p> <p>Measures include:</p> <ul style="list-style-type: none"> • Free condom provision for medium and high risk groups • Outreach programmes for high risk, hard-to-reach groups • Provision of HIV risk reduction messages in gay bars • Needle exchange provision for injecting drug users • High quality integrated sex and relationship education (SRE) reduces teenage pregnancy rates, STI rates and sexually harmful behaviour.
Prevention of STIs and under 18 conceptions	<ul style="list-style-type: none"> • Assess people's risk of having a sexually transmitted infection (STI), when the opportunity arises. For example, when someone attends for contraception, or to register as a new patient • Where appropriate, provide one to one sexual health advice to young people on: <ul style="list-style-type: none"> – how to prevent and/or get tested for STIs and how to prevent unwanted pregnancies – all methods of reversible contraception, including Long Acting Reversible Contraception (LARC) how to get and use emergency contraception – other reproductive issues and concerns. • Provide supporting information on the above in an appropriate format

Work area	Interventions
HIV prevention interventions specifically targeting men who have sex with men (MSM)	<ul style="list-style-type: none"> • Risk reduction education • Safer sex skills training sessions/cognitive behavioural interventions, peer leader interventions • Interpersonal skills training • Peer support • 1:1, group and community level interventions • Multiple delivery methods • Interventions targeting BAME MSM and younger populations • Increasing uptake of HIV testing through: <ul style="list-style-type: none"> – Assessing local need, developing a strategy and planning services accordingly – Promoting HIV testing among men who have sex with men – Offering and recommending an HIV test for all men who attend specialist sexual health services – Offering and recommending HIV test to all men who register with a GP practice – Providing rapid point-of-care tests – Ensuring clear referral pathways for people with positive and negative HIV test results.
HIV prevention interventions specifically targeting African Communities	<ul style="list-style-type: none"> • Health promotion, HIV risk reduction interventions specifically targeting African communities (Every case of HIV prevented saves the NHS saves over £350,000) • Targeting interventions at different black communities that include culture specific materials to support health promotion interventions • Interventions designed specifically to target African women and girls using gender- or culture-specific materials and delivered by women • Knowledge/skills building and interpersonal skills training • Using role-playing to teach negotiation skills for women and girls • Skills training in condom use and negotiation of safer sex for women and girls • Increasing uptake of HIV testing through: <ul style="list-style-type: none"> – community engagement – assessing local need, developing a strategy and planning services accordingly – promoting HIV testing for black African communities – reducing barriers to HIV testing – offering and recommending HIV test in healthcare settings – ensuring clear referral pathways for people with positive and negative HIV test results.

Sexual and reproductive health services in Waltham Forest cover most of the interventions in Table 7.1 above. From discussions with service users, clinicians and other service providers, the following areas were identified as needing strengthening within local sexual and reproductive health services:

- Increasing uptake of LARC – currently available at Oliver Road and some GP practices; it is not clear what is provided in GP practices. Having more GPs trained in providing LARC would increase access
- Effective partner notification in sexual and reproductive health services
- Health promotion, tackling stigma
- High quality integrated Sex and Relationship Education (SRE)
- STI treatment services in groups at high risk. STI treatment is currently only available at Whipps Cross Hospital
- Access to services with very short/no waiting times. Currently there are long waiting times at both Oliver Road and Whipps Cross
- Provision of HIV testing in a range of settings
- Training of non-specialist healthcare professionals.

What is being done locally to address sexual ill-health?

Our aim is to ensure that integrated sexual and reproductive health services meet the sexual health needs of Waltham Forest residents and improve health outcomes by providing quality and holistic services in the right place, at the right time, by the right people and at the right cost.

Some sexual health services such as Chlamydia screening are currently commissioned in collaboration with other boroughs in outer north east London to increase efficiency and value for money. Other services such as HIV prevention are commissioned London-wide.

Delivery of sexual health services in Waltham Forest occurs in primary care, secondary care and community services. Our sexual health services cover the following areas:

- STI and HIV testing, diagnoses and treatment
- Care and support for people living with HIV
- HIV prevention programme delivered across London
- Family planning, including LARC provision
- Emergency Hormonal Contraception (EHC) and pregnancy testing in pharmacies
- Sex and relationships education in schools
- Teenage pregnancy prevention work with young people
- Condom distribution scheme for young people
- Abortion services.

Sexual Health Steering Group

The Waltham Forest Steering Group brings together commissioners from both the NHS, Local Authority and service providers to oversee the assessment of needs to feed into the Joint Strategic Needs Assessment (JSNA), priority setting and strategy development using available evidence. The group is chaired by the Public Health Sexual Health Lead.

Local services

Sexual health services in the borough cover the whole pathway from prevention, early detection, treatment to rehabilitation. HIV services are set out at each stage of the pathway.

Prevention – e.g. Pan London HIV Prevention Programme (PLHPP), World AIDS Day, education and support for people living with HIV to teach them skills to avoid onward transmission, Sex and relationship education in schools; teenage pregnancy prevention work with young people; family planning including provision of free condoms and emergency hormonal contraception (EHC) to young people

The PLHPP was developed to provide a London-wide HIV prevention programme to address the increasing prevalence within the capital. Each local authority contributes to the programme's budget. The programme is currently commissioned and managed by London Borough of Lambeth on behalf of all London boroughs. This programme is under review, with an ongoing needs assessment to inform future direction. The main strands of work are:

- covers health trainers
- sexual health counselling
- group work.

Early Identification – e.g. screening for Chlamydia and other STIs to diagnose those with infection and provide prompt treatment; HIV testing to facilitate early diagnoses at Oliver Road and Whipps Cross Hospital.

Treatment – Comprehensive sexual health services at Whipps Cross Hospital; community sexual and reproductive health services; abortion services for women and girls who have unwanted pregnancies.

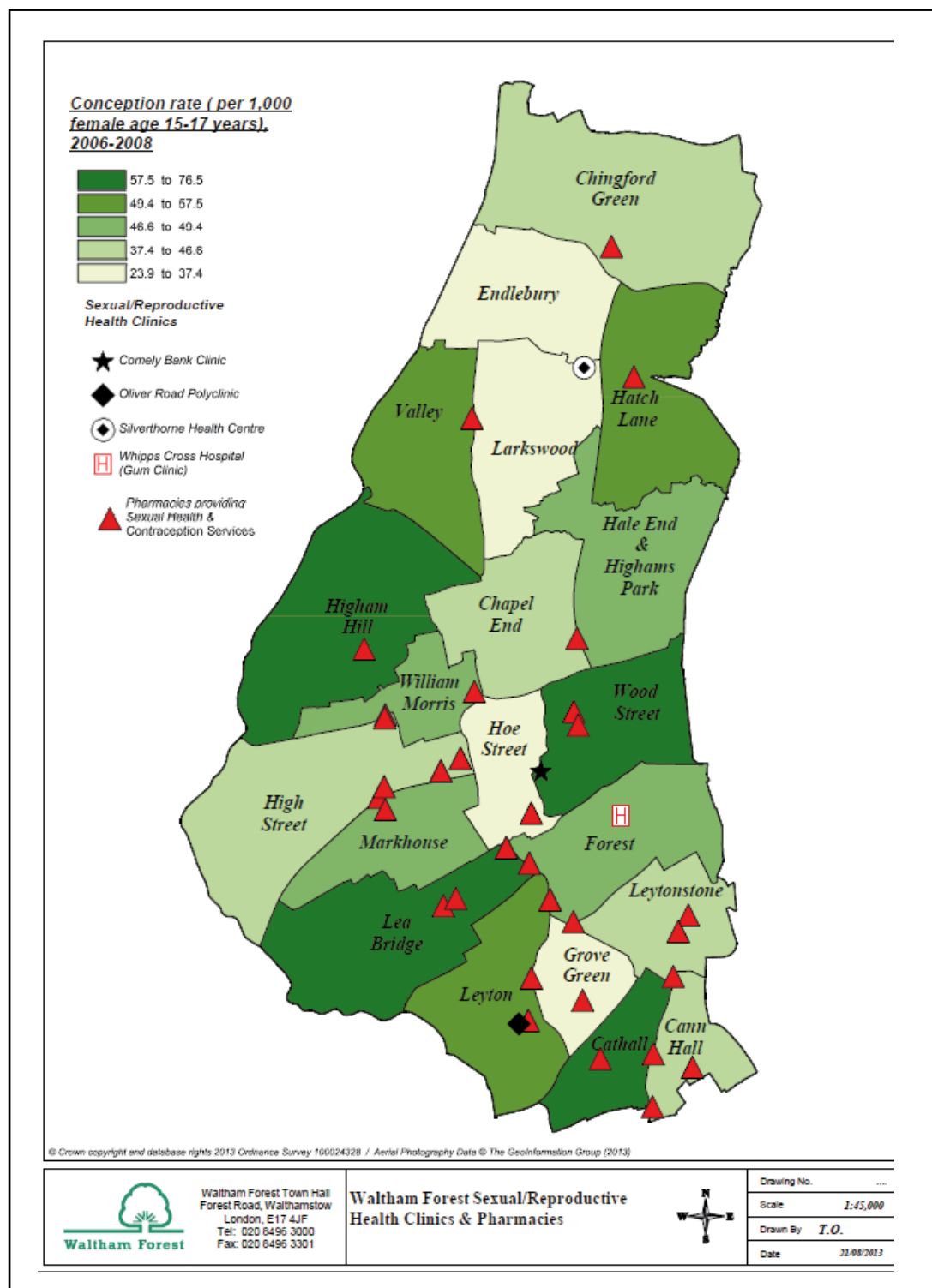
In addition to clinic-based services, there are outreach services targeting young people and some high risk groups such as Looked After Children, especially in Chlamydia screening and teenage pregnancy prevention. Waltham Forest is part of the pan London condom distribution scheme (c-card) that allows young people, (up to 25 years) once registered onto the scheme, to obtain free condoms from a number of outlets in Waltham Forest and other participating boroughs. The vast majority of our Chlamydia screening is provided by the voluntary sector.

Pharmacies

London Borough of Waltham Forest commissions community pharmacies in to provide free Emergency Hormonal Contraception (EHC or morning after pill), pregnancy testing and signposting information about family planning clinics to women of all ages. This is to help avoid unwanted pregnancies; and for those women who decide to keep a pregnancy following a test, to ensure prompt referral to maternity services. The Council has commissioned a pharmaceutical needs assessment (currently underway), which will provide detailed information about sexual health service provision in pharmacies.

Figure 7.11 shows the locations of the different sexual health services in the borough against a background of teenage pregnancy rates.

Figure 7.11 Location of sexual and reproductive health services in Waltham Forest



Evidence that we are making a difference

Since the last JSNA there has been progress in sexual and reproductive health service provision in Waltham Forest. The Community Sexual and Reproductive Health Service has appointed a substantive Consultant Community Gynaecologist and the service is working with the Whipps Cross Department of Sexual Health to improve sexual health provision. The service now provides asymptomatic screening for Chlamydia, gonorrhoea, HIV and Syphilis; and provides treatment for Chlamydia with partner notification.

Whipps Cross Department of Sexual Health (DOSH) has also made a number of improvements. These include:

- Better testing platforms for STI, via the laboratory at Royal London Hospital, to include nucleic acid testing (dual NAATS) for everyone attending the clinic. The benefits include more patient-friendly tests (urine instead of urethral swabs in men and self-taken swabs in women with no symptoms) and increased accuracy for detection of gonorrhoea. More recently, they have received approval to use dual NAATS for pharyngeal samples also
- Slot system – patients are allocated a slot at the time of registration (depending on the number allocated on arrival, they are told the likely time to be seen)
- We are looking to improve our results management further by using a centralised results system, where an interface between Preview (IT system) and the lab will allow a faster turnaround for results (currently 10-14 days, will reduce to 3-4 days). This will ensure faster partner notification and treatment of STIs
- Each patient is now receiving SMS results; as part of the merger within Barts Health they will be able to access the results by telephoning an access number (telephonetics)
- Access to research for patients attending DOSH, now recruiting to AURAH (Attitudes to and Understanding Risk of Acquisition of HIV)
- As part of the merger, we will have increased access to a wide range of specialists, including psychology for sexual health. Psychology clinics are due to start in DOSH 4 November 2013
- There is a wide range of consultant expertise within Barts Health, specifically in younger people services, sexual assault, sexual violence and complex contraception
- DOSH will provide contraception from 4 November, in a phased way, initially simple contraception, hoping to expand to LARC next year
- DOSH is currently providing a walk-in rapid HIV testing service in out-patients, no appointment necessary. So far, 250 patients have been tested and 3 positives found.

The pan London young people's condom distribution scheme (c-card) is now firmly established in Waltham Forest and is being rolled out to a number of services. Participants include Youth Support Services, Youth Offending Team, sexual and reproductive health services in the community and Whipps Cross Hospital. The scheme allows young people to obtain free condoms in a variety of outlets in Waltham Forest and other participating London boroughs. The scheme will be rolled out to pharmacies shortly.

There are still some challenges/gaps in meeting the sexual health needs of Waltham Forest. These include:

Gaps in provision

The following gaps were identified through the stakeholder consultation:

- Lack of clarity on pathways
- Absence of integrated sexual and reproductive health service
- Low involvement of primary care in sexual and reproductive health service provision

- Lack of psychosexual counselling services (e.g. for sexual dysfunction)
- Absence of dedicated young people's service
- Absence of level 2 sexual health services in the community
- Lack of local health promotion initiatives
- Inadequate HIV testing in the community.

Risks to current service provision:

- Open access, cross charging – higher unpredictable costs
- Year-on-year increase in activity
- 30% increase in follow-up GUM PbR tariff
- Waltham Forest residents using out of borough provision which may incur higher costs.

To mitigate the financial risks, London Borough of Waltham Forest has contracted the North and East London Commissioning Support Unit to monitor the GUM contract for this year (2013/14). This is to help in challenging and validating invoices during the first year as the Council develops a more permanent system.

The arrangement is in collaboration with three other boroughs – Hackney and The City, Newham and Tower Hamlets. This will ensure a common negotiating position with providers and help agree contracts with the 'biggest' providers, aiming to maintain the 2012/13 prices. In the long term we need to develop a high quality integrated sexual and reproductive health service with the main hub in an accessible central location in the borough. This would improve access and help retain residents in local services.

What is the patient and public perspective?

A recent review of sexual and reproductive health services in Waltham Forest sought views of stakeholders – patients and the public, clinicians, commissioners – through interviews, focus groups and young people's survey. Overarching themes from the review are:

- Once seen, patients are generally very satisfied with the care they receive from clinicians, especially those accessing HIV care. Patient surveys led by North East London Sexual Health and HIV Network (NELNET) have shown that patients were satisfied with the care they received
- The majority of patients seen in GUM present with symptoms, are often young or from vulnerable groups
- Concerns regarding Oliver Road clinic. These include location (not easily accessible, gang and safety issues preventing young people from going there), limited information on services provided, changes in service provision not communicated well, long waiting times, lack of privacy in reception area (one respondent noted that 'you can request a room by reception for privacy' but this does not seem to be widely known), difficulties getting someone to speak to on the telephone, vacant posts, appointments not available for family planning, patients 'routinely' inappropriately referred on to Whipps Cross⁴¹²

⁴¹² Note from the provider: All clients are offered the opportunity to speak in confidence in the confidentiality room. The telephone system is currently being reviewed to provide more information to patients about opening times, how to book appointments and self-help information. We are not aware of patients experiencing difficulties accessing appointments but we are cognisant that there is a possibility patients may not receive the appointment times they request. Finally, referral to Whipps Cross is routinely for symptomatic patients who access Oliver Road, except for patients with Chlamydia who receive treatment from suitably qualified clinicians.

- No dedicated young people's service in the borough. Need at least young people friendly services that are 'you're welcome' accredited and perhaps for 'one stop shop' in Walthamstow Central providing a wide variety of services for young people (e.g. careers advice, sexual health, mental health, substance misuse, etc.); supported by effective targeted outreach strategy and service for those who find it difficult to engage
- Services need to build stronger links with education – colleges, schools, Pupil Referral Unit (PRU), Looked After Children (LAC) – and young people in general
- Poor communication/publicising of what services are available where, including GP practices – websites out of date, poor communication between professionals, lack of easy access through social media
- Opening times to be longer (e.g. Oliver Road closes at lunch time) to match patient needs and communicated clearly
- Lack of health promotion and prevention initiatives
- Lack of consistency in provision. Service changes not communicated promptly
- Lack of psychosexual counselling service
- Lack of awareness of services provided by voluntary sector organisations
- Sexual health service provision is patchy, with lack of clarity on pathways to service users and clinicians.

What more do we need to know?

- Systematic collection of LARC and EHC data from all services to identify any inequalities in access and target groups with poorer access
- An understanding of the most efficient way(s) of implementing HIV testing in Waltham Forest in order to increase access
- A better understanding of the need; and the role of sexual health services in addressing the following issues:
 - street sex workers
 - sexual exploitation/sexual violence
 - sexually harmful behaviours among young people.

What are the priorities for improvement over the next five years?

Key insights

- As with other parts of the country, teenage pregnancy rates in Waltham Forest are associated with deprivation – areas with high deprivation generally have high rates of teenage pregnancy
- Community sexual and reproductive health clinics are not equitably located within the borough and the locations are not necessarily linked to need
- There are high rates of STIs, HIV and late HIV diagnoses in Waltham Forest. This could be linked to lack of sustained health promotion and prevention interventions; and inadequate HIV testing initiatives.
- Waltham Forest has high rates of abortion and repeat abortions. This indicates high rates of unprotected sex and suggests lack of awareness of, or inadequate contraception services
- With the fragmentation of commissioning responsibilities for sexual health services, a co-ordinated response among commissioners (Local Authority, CCG, NHS England) is required to tackle sexual violence within the context of violence against women and girls

- Increase in complex need among people living with HIV due to:
 - ageing population
 - restrictions in social care and state support including welfare benefits and housing
 - increasing low grade cognitive and mental health issues
 - rise in associated health conditions due to drug resistance and long-term use of anti-retroviral.

7.3 Tuberculosis and Hepatitis B and C

Executive summary

London continues to account for approximately four in ten tuberculosis (TB) cases reported across the UK.⁴¹³ Rates are highest among London residents aged 20-29 years old and continue to increase in this group, in particular among males. Cases also continue to occur among children aged under five years old, almost all of whom were born in the UK.¹ The majority of cases were born outside the UK, but numbers and rates in both UK and non-UK born populations have remained stable in recent years. Of those born abroad, over 80% had been in the UK for two or more years prior to diagnosis. TB continues to be an area of concern in Waltham Forest and this JSNA highlights the current issues.

Recommendations

The changes required to reduce the rates of TB in Waltham Forest include:

- Early identification of people with infectious TB – Training for primary care professionals and other health professionals to increase and maintain awareness of TB in order to increase early diagnosis of TB. Re-launching the patient's pathway.
- Awareness strategies targeted at the most affected communities in the borough i.e. Black African, Pakistani and Indian communities
- Ensure that there is one specialist TB nurse per 40 new cases
- Homeless people and people with substance abuse problems also need to be targeted
- Ensure community clinics delivering the neonatal BCG vaccine are appropriately resourced and accessible to deliver the high number of BCG vaccines to babies in a timely manner
- Ensure GPs refer children between the ages of 1 to 5 years who have not received the BCG vaccine to community clinics
- Reinstate the targeted School Nursing Service delivery of Mantoux testing and BCG vaccine in Secondary schools in Waltham Forest
- Ensure that effective components of TB management and control are implemented locally including:
 - access to GP registration for hard to reach and vulnerable people
 - BCG immunisation
 - early diagnosis and treatment
 - contact tracing.
- TB awareness and TB Health Promotion should be included in commissioning plans

⁴¹³ Tuberculosis in London: Annual review (2012 data), 2013. London: Public Health England, October 2013, http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317140109893

- A programme to raise awareness of TB amongst health and social care workers so that they can recognise early signs and refer people with suspected TB to the appropriate service. A&E staff, midwives and housing and social workers
- Use of community pharmacies or the third sector and community organisations to deliver DOT (Directly Observed Therapy).

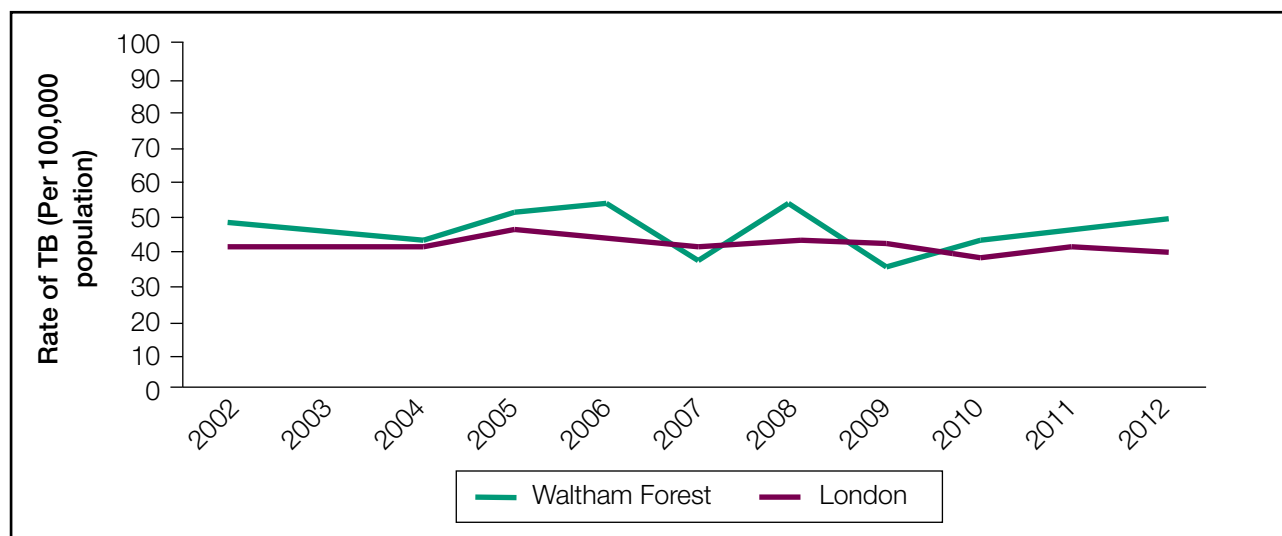
Local picture

The TB rate in Waltham Forest was 49 per 100,000 in 2012. It has increased since 2009, but has remained around 40-50/100,000 over the last decade, mostly above the London rate (see Figure 7.12). Patients were predominantly males, with 20 to 29-years-old the most common age group. Almost a quarter were UK born (higher than in most areas of London): just 13% were recent migrants, having entered the UK within two years of diagnosis, while 25% had been in the UK ten or more years. The most common ethnic group was Pakistani: almost a quarter of these were UK born. Levels of drug resistance were similar to the London average. One in ten patients had one or more social risk factor (and 17% of those with pulmonary TB): this was most commonly drug use. The proportion completing treatment was similar to the London average.

The rate of new cases of TB in Waltham Forest is higher than the regional and national averages: in 2012, the rate was 41 per 100,000 in London and 14 per 100,000 in the UK.⁴¹⁴

Figure 7.12 below shows the TB incidence rate for 2002–12 for Waltham Forest and London.

Figure 7.12 TB Incidence rate for the period 2002–12



Who is most at risk?

The groups at higher risk of contracting TB are:

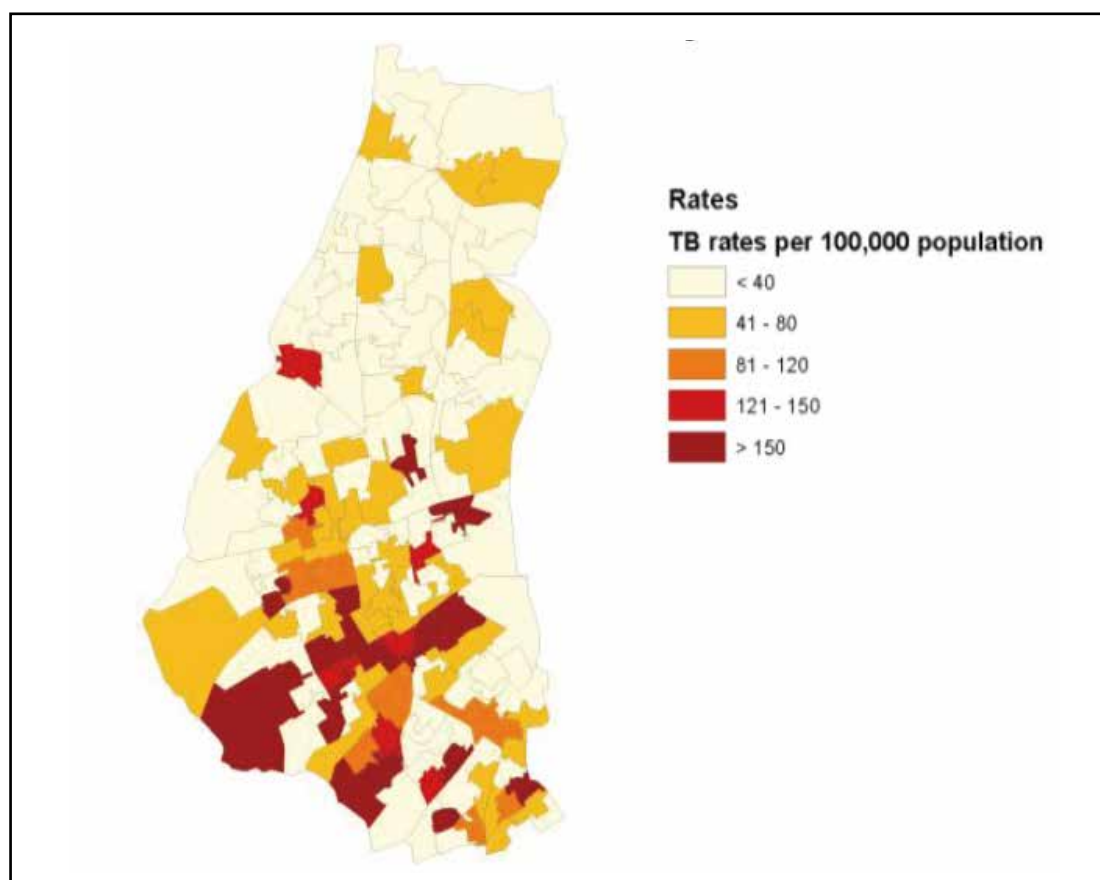
- Individuals born in countries with high rates of TB
- People living in unhealthy and overcrowded conditions
- People with a history of drug use
- Prison/ex-prison population
- Homeless people

⁴¹⁴ Public Health England Tuberculosis in the UK: Annual report on tuberculosis surveillance in the UK, 2013, http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317139689583

- People who are immunosuppressed
- People living with HIV
- Refugees
- Certain BAME communities
- People with occupational exposure⁴¹⁵.

Overcrowding is one influence on incidence of TB. In the 2011 census overcrowding in Waltham Forest was 23.2%, affecting 22,445 households. This compared to London at 21.7% and England at 8.7%⁴¹⁶. The most overcrowded ward at the 2011 census was Cathall at 32.4%.⁴¹⁷ The majority of TB cases were concentrated in the southern part of the borough where there were high levels of domestic overcrowding and poverty (see Figure 7.13 below).

Figure 7.13 Incidence rate by small areas (LSOA) 2012



⁴¹⁵ TB Alert 2010, The Truth About TB, www.tbalert.org, date accessed 7/09/2010.

⁴¹⁶ ONS Census 2001.

⁴¹⁷ Local Health, <http://www.localhealth.org.uk/#v=map7;l=en>

TB notifications are higher in males than in females. Figure 7.14 below shows that in 2012 TB notifications in the 20 to 29 age group were the most affected for men with the 30 to 39 age group the most affected for women.

Figure 7.14 TB Notifications by age and sex, 2012

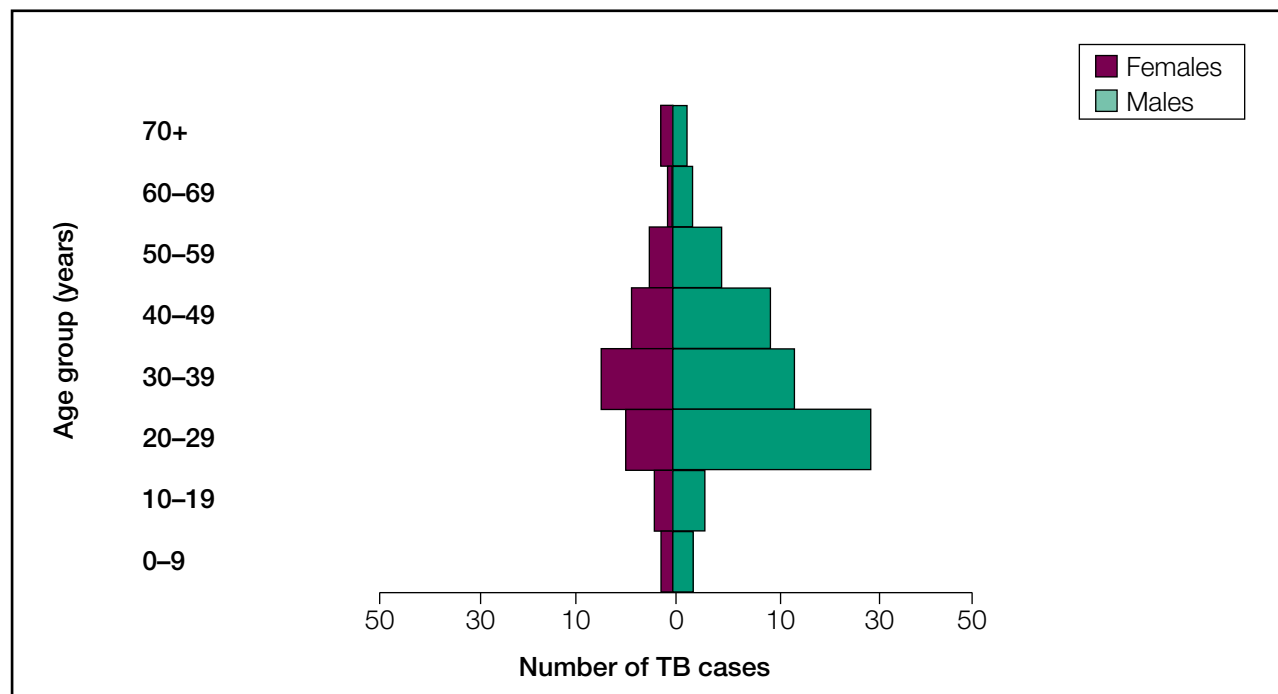
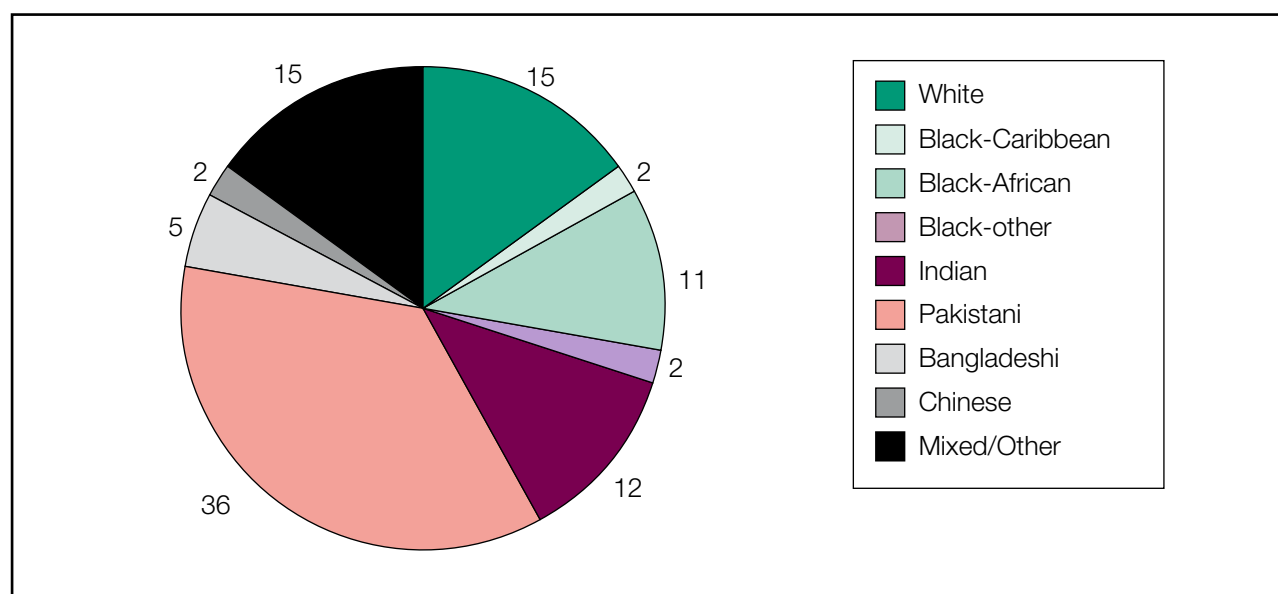


Figure 7.15 below shows the TB cases by ethnicity in 2012. It indicates that the most affected were Pakistani with the least affected being the Chinese, black-Caribbean and black-other.

Figure 7.15 Percentage of TB cases by ethnicity, 2012



Current issues in Waltham Forest

Barts Health NHS Trust

- Staffing levels remain inadequate, especially on the Whipps Cross Hospital site:
For the TB case load managed by Barts Health, NICE recommend 21 whole time equivalent (WTE) nurse case managers. Barts Health currently employs 15.4 WTE nurses and is planning on cutting 3 of these posts
- High number of infectious cases being seen in the chest clinic
- TB nurses now doing home visits as more complicated cases and complex issues are being seen including drug resistant cases
- BCG – due to changes in the provision of BCG vaccine within the community Whipps Chest Clinic are receiving queries from GPs and the public regarding BCG vaccination for children meeting the criteria
- Patients with suspected TB in the community are being referred via Choose and Book.

Community

North East and North Central London Health Protection Team work closely with Barts Health TB service to implement contact investigations for infectious cases of TB. These risk assessments and the subsequent screening of exposed close contacts is vital for identifying co-primary and secondary cases and thus preventing spread in the community and further cases.

Over 30 risk assessments and large scale screening exercises have been necessary in a variety of community settings in the last 3 years in Waltham Forest, including in secondary schools and 6th form colleges, adult education colleges, hostels for homeless and vulnerable people, large Church congregations, several workplaces and Whipps Cross Hospital.

Screening in such settings is challenging, requiring the TB nurses to deliver screening tests on a large scale, on school premises for example. The investigations often cause considerable anxiety for members of the public, parents, teachers and employers. The risk of spread of TB in these settings is low and it is currently rare to find evidence of transmission. However this may be jeopardised if immunisation and school nursing services are not maintained in the borough.

BCG vaccination

BCG vaccine is given to neonates in Waltham Forest, as per national guidance, in community clinics delivered by North East London Foundation Trust (NELFT) community services. In 2012, due to staff changes, a backlog of babies requiring BCG vaccine had built up. Following intensive work and more staff brought into the borough from other areas, the backlog was cleared.

The service needs to ensure it is adequately resourced to deliver the high number of BCG vaccines to the community in a timely manner, ensuring high uptake is maintained locally, easily accessible service for families who rely on public transport and service delivery is suitable to cultural needs.

BCG vaccine should also be available to any child under the age of 16 who is at high risk of exposure to TB (as per nationally agreed criteria) e.g. those children who have families who are from countries where TB is endemic (greater than 40 cases/100,000 population). A large proportion of children who move into Waltham Forest require BCG vaccine and population mobility is high. For Children between the ages of 1 to 5 years, who may have moved into the borough or who have previously not received the BCG vaccine, GPs are able to refer them to the community clinics for the vaccine.

Previously, the School Nursing Service in NELFT delivered a targeted Mantoux and BCG vaccination programme in secondary schools to high risk children who had not received the BCG vaccine. This included referral arrangements for any further testing and treatment as necessary. The service worked very well, however, due to staff shortages, the service was stopped by NELFT in 2012 and has not been reinstated.

Partnership working

The Health Protection Team works with local public health colleagues to raise awareness about TB in established local colleges. There are an increasing number of 'adult education colleges' emerging which attract many students from overseas. The recent increase in cases of infectious TB amongst students at these colleges is of real concern. Further work is necessary to identify and engage with these establishments so that students can be provided with advice and engaged with local health services.

Hepatitis B and C

Executive summary

Blood Borne Viruses (BBV) represent a challenge to health within Waltham Forest both through the recognised issue of infection in illicit drug users and the global reflection of BBV endemicity in the Borough's rich and diverse ethnic communities.

Traditionally Hepatitis B is considered to be a reflection of migrant communities from countries where the Hepatitis B virus is endemic and Hepatitis C a home-grown phenomenon of people who inject drugs. This UK generalisation may not apply in Waltham Forest.

The 2011 Census data indicates that around 10% and 2% of the population of Waltham Forest are of Pakistani and Bangladeshi origin and these figures are rising. The prevalence of Hepatitis C Virus (HCV) in people from South Asia – particularly Pakistan – is five times that of the wider UK population and over 10% of people who died from HCV in the UK between 1996 and 2009 were born in Pakistan or Bangladesh⁴¹⁸. In addition, new challenges with respect to migration to Waltham Forest from new European Union Ascension countries which have high prevalence of BBV. Waltham Forest has the second highest percentage (9%) across London of residents from EU accession countries (London Borough of Waltham Forest website).

BBV services for drug users, particularly vaccination for hepatitis B and testing for hepatitis C has improved due to improved service delivery across the drug treatment partnership. However much more needs to be done to improve testing for those outside the drug treatment services who belong to the at risk group.

Hepatitis B

Public health action focuses on:

- Surveillance to monitor local trends in incidence (burden of known infections in children and high risk populations e.g. GUM clinic attenders; IVDUs; prisoners)
- Identifying and addressing local routes of transmission and so preventing new infections (safe sex education; needle exchange programmes)
- Informing local vaccination priorities (at risk groups including health care staff)
- Increasing opportunities for testing and treatment⁴¹⁹
- Ensuring timely follow-up and treatment of cases and contacts (ensuring clear care pathways)
- Ensuring continued robust follow-up of children born to hepatitis B positive mothers to ensure completion of vaccination course and screening at 1 year of age.

⁴¹⁸ <http://pathways.nice.org.uk/pathways/hepatitis-b-and-c-testing>

⁴¹⁹ *Ibid.*

Hepatitis C

Public health action should focus on:

1. Prevention of new infections (commissioning a broad range of prevention services e.g. those encouraging injectors to quit; reducing risky behaviour – needle exchange systems).
2. Increasing awareness of infection and subsequent increasing of testing in vulnerable populations especially South Asians and EU ascension country migrants (working with the voluntary sector to support local awareness campaigns).
3. Increasing testing and diagnosis⁴²⁰. New testing initiatives (most testing is done in primary care, Dry Blood Spot (DBS) and oral fluid in drug services; GUM services); ensure testing reaches high risk local populations; early referral as new treatments may be effective at clearing the virus (up to 80% success if genotype is favourable).
4. Active and continued support of antenatal/perinatal testing.
5. More awareness of travel risks for visiting friends and relatives, Hajj and those seeking medical treatment overseas.
6. Getting diagnosed people into treatment and care as only a small proportion of those testing usually receive treatment (ensuring good care pathways are in place).

Hepatitis C

Hepatitis C is a major public health problem. An estimated 58,000 people in London (215,000 adults in UK) are infected and 40% of these remain undiagnosed.⁴²¹ Hepatitis C is a blood borne virus which may not be cleared in up to 80% of those who are infected. Persistent infection can lead to chronic liver disease, cirrhosis and hepato-cellular carcinoma (HCC) in later life. The burden of hepatitis C hospital admissions and deaths from hepatitis C related liver disease and HCC have risen threefold since 1998, and continue to rise.

Injecting drug use is the major risk factor for acquisition of hepatitis C (accounting for 69% of cases in London). Sex between men, especially those who are HIV positive is another important transmission route. Some countries e.g. those in South Asia, have a higher prevalence of hepatitis C, people who were born or have received medical treatment in countries where the prevalence of hepatitis C is likely to be higher are at increased risk of infection.

Hepatitis C has high health and financial costs. In London the costs of treating those already identified is estimated at £29 million and current annual treatment costs are £5.7 million (assuming 5% of people infected are identified each year)⁴²².

Using the same models it is estimated that 1,365 people have hepatitis C in Waltham Forest. By 2015 there will be a projected 874 with mild to moderate liver disease, 43 with cirrhotic or end stage liver disease and 93 who will have died as a result of the infection. It is estimated that it will cost £680,980 to treat those already identified in the borough and £135,046 to treat additional cases (if 5% of people infected are identified each year).

Waltham Forest is categorised in the 'HIGH' group for prevalence of HCV together with 24 other borough in London, which means that over 50% of those who injected in the last year were HCV positive.⁴²³

⁴²⁰ <http://pathways.nice.org.uk/pathways/hepatitis-b-and-c-testing>

⁴²¹ Health Protection Agency – Hepatitis C in the UK 2013.

⁴²² Health Protection Agency 2012, Hepatitis C in London Annual Review (2011 data).

⁴²³ Health Protection Agency 2009, Hepatitis C in London.

Hepatitis B

Hepatitis B virus (HBV) infection is another global health problem. HBV is highly infectious and is transmitted mainly through sexual intercourse, perinatal transmission during childbirth, injecting drug use and blood-to-blood contact. HBV can cause acute or chronic infection. Most of the disease burden is due to chronic infection, which may be asymptomatic for many years but is associated with an increased long-term risk of cirrhosis and hepatocellular carcinoma.

In countries with a high prevalence of HBV most infections are acquired perinatally or in childhood. The prevalence in the UK is low but varies across the country where there may be local populations born in high-endemic countries. Acute infections in the UK give rise to fewer than 10% of all new chronic infections, these being mostly attributable to the immigration of carriers. Most new infections in the UK are acquired through adult risk behaviour i.e. sexual contact and intravenous drug use.

Infected mothers can pass on the virus to their babies during the time of birth. Babies infected at birth are very likely to develop chronic infection unless they are vaccinated from birth. Since 2000, all pregnant women have been offered testing for hepatitis B. For babies requiring hepatitis B vaccinations (due to mothers being infected with hepatitis B and to prevent onward infection), in 2012/13, 88.4% (38 out of 43) of babies received their vaccination by 12 months (3 doses of Hep B). For babies reaching 24 months in 2012/13, Waltham Forest had an uptake of 90.7% (49 out of 54). For 12 months, the Hep B coverage has decreased from 2011/12 to 2012/13 when it was 100%. For 24 months coverage remained the same as in 2011/12.

What are the effective interventions?

The key policy drivers in relation to blood borne viruses are:

- Tackling The Problem of Hepatitis C, Substance Misuse and Health Inequalities: A Consensus for London, The London Joint Working Group for Substance Misuse and Hepatitis C (LJWG) 2012
- *Good Practice in harm reduction*⁴²⁴ (published by the National Treatment Agency for Substance Misuse, now part of Public Health England) highlights good practice in harm reduction especially for blood-borne viruses and overdose
- '*Hepatitis C Action Plan for England*'⁴²⁵ is best practice guidance published in 2004 to aid implementation of the Government's Hepatitis C Strategy for England (2002)
- NICE guidance on needle exchange and syringe programmes.⁴²⁶ This guidance provides recommendations for good practice, based on the best available evidence of effectiveness, including cost effectiveness
- Public Health England's *Shooting Up* reports⁴²⁷ focus solely on infections among people who inject drugs in the UK. This report focus on the current prevalence of the main viral (Hepatitis A, B, C and HIV) and bacterial (staphylococcus aureus, group A streptococcal and clostridium) infections as well as making recommendations
- The Safer Injecting Briefing (Drug Scope, 1999) guidance covers areas such as the evidence-based for promoting safer injecting, routes of administration, vein damage, and transmission of blood-borne viruses and providing comprehensive services to tackle unsafe injecting practices
- NICE⁴²⁸ has produced a number of guidance reports on hepatitis B and C.

⁴²⁴ http://www.nta.nhs.uk/uploads/nta_good_practice_in_harm_reduction_1108.pdf

⁴²⁵ <http://www.nhs.uk/hepatitisc/SiteCollectionDocuments/pdf/hepatitis-c-action-plan-for-england.pdf>

⁴²⁶ <http://www.nice.org.uk/nicemedia/live/12130/43301/43301.pdf>

⁴²⁷ <http://www.hpa.org.uk/Publications/InfectiousDiseases/BloodBorneInfections/ShootingUp/>

⁴²⁸ <http://www.nice.org.uk/>

There are 2 key performance indicators, which are monitored by the National Treatment Agency:

- All Service Users to be offered hepatitis B vaccinations – measured by the proportion of service users offered hepatitis B vaccination:
 - Waltham Forest has set services a target of 100% in 2013/14.
- All current or previous injectors to be offered Hepatitis C testing (and subsequent treatment) – measured as the proportion of current or former injectors offered Hepatitis C testing:
 - Waltham Forest has set services a target of 100% in 2013/14.

Of the new treatment journeys in 2012, 100% had a vaccination status for hepatitis B recorded. Of these, 62% were offered and accepted the Hep B vaccination, 24% refused the Hep B vaccination, 13% were already immunised and 1% had acquired immunity.⁴²⁹ Individuals who started a course of treatment were 11% and those who have finished the course of Hep B treatment was 70%.

Those starting a new treatment journey in 2012 were 252; of these 72% of individuals in treatment previously or currently injecting received a Hep C test. 79% of individuals were offered and accepted a Hep C test and 19% refused. However 2% of these were assessed as not appropriate to offer.

What evidence is there that we are making a difference?

The new 10-year government strategy aims to get problem drug users into effective treatment, to reduce drug related offences and re-integrate into society to reduce harm to families and communities.⁴³⁰

A substance misuse needs assessment and service review has been conducted. The aim of this is to:

- identify the substance misuse related needs of the people of Waltham Forest
- describe the wider impacts, risk and harms associated with the substance misuse
- support the substance misuse service reconfiguration process
- inform the commissioning strategy.

What are the priorities for improvement over the next five years?

Please see 'Public Health Action focuses on' in the recommendation section at the beginning of the chapter.

⁴²⁹ NDTMS Adult Partnership Performance Report 2012/13, Quarter 4 Waltham Forest.

⁴³⁰ 2010 Drug Strategy consultation document.

8

Older people

8.1 Older people: dementia and other long-term conditions

Executive summary

The mid-year population estimates based on the 2011 Census population data reported that there are 259,742 people within the London Borough of Waltham Forest (LBWF) and 25,770 (9.92%) are aged 65 and over.⁴³¹

The number of older people is projected to increase from 25,770 in 2011 to 28,386 by 2021⁴³². Chingford has the highest proportion of older people out of the three GP Consortia.⁴³³

The index on income deprivation affecting older people in Waltham Forest is significantly higher compared to the England average.

The black, asian and minority ethnic (BAME) group is growing at a faster rate compared to the rest of the population.

Factors influencing health and wellbeing

Living environment

Living environment has a great influence on health and wellbeing. Older people in Waltham Forest older people have lower levels of satisfaction with their homes and neighbourhoods than London and England.

Health and wellbeing indicators and inequalities

Life expectancy in Waltham Forest as of 2010–12 for men is 79.2 years and 83.4 years for women and these rates are similar to London and national rates and increasing.⁴³⁴

Waltham Forest has similar rates to the England and London average for life expectancy at age 65 for both males and females.⁴³⁵

This National Service Framework (NSF) for Older People and LTCs

This NSF for Older People was the first ever comprehensive strategy to ensure fair, high quality, integrated health and social care services for older people. It continues to be relevant and underpins Waltham Forest's Joint Strategic Needs Assessment to inform commissioning priorities for older people.

Mental health disorders

Older people are vulnerable to depression, especially those living alone or in residential/nursing care and those with physical illnesses and disabilities.

⁴³¹ Office for National Statistics (ONS) – Estimated resident population Mid-Year Estimates based on 2011 Census.

⁴³² Office for National Statistics (ONS) – Sub national population projections 2011 Interim Census-based.

⁴³³ GP registered population.

⁴³⁴ Office for National Statistics (ONS) Life Expectancy 2010–12.

⁴³⁵ *Ibid.*

Dementia

Nationally, 5% of people aged 65+ are affected with dementia. The most common form of dementia is Alzheimer's disease. Vascular dementia is also important and accounts for around 17% of all cases of dementia. Vascular dementia is potentially preventable since its aetiology is the same as other cardiovascular disease e.g. stroke and ischaemic heart disease.

The number of people diagnosed with dementia in Waltham Forest is 987 which is 0.34% of the population.⁴³⁶ Despite the relatively low recorded prevalence, emergency admission rates for dementia in Waltham Forest from 2009/10 to 2011/12 were consistently higher than London and national rates.⁴³⁷ For all three GP localities the age standardised emergency admission rates were higher in 2010/11 compared to 2008/09.

Improving timely detection is a key priority as people who are diagnosed early have better outcomes. Waltham Forest has a high detection rate for dementia compared with other Authorities. Figures from the Alzheimer's Society ('mapping the dementia gap') put the rate at 58% in 2012, ranking Waltham Forest at 24th out of 178.

Limiting long-term ill-health (LLTI)

Cardiovascular Disease (CVD) is the largest single cause of long-term ill-health and disability, among older people nationally. These areas warrant more strategic commissioning investments underpinned by unmet needs and service gaps (CVD is discussed in more detail in Chapter 6).

In 2012 it is estimated that there were approximately 13,240 older people living with a limiting long-term illnesses (LLTI) and by 2020 this is expected to increase by 6.5% thereby placing further demand on health and social care.⁴³⁸

It has been estimated that if the current system remains unchanged, then the cost of disability benefits could rise by almost 50 per cent in the next 20 years, while the cost of long-term care could rise by 17 per cent by 2027/28 nationally.

Emergency admissions related to cardiovascular disease and diabetes

Older people constitute a high proportion of the increasing admissions to acute care. The non-specific manner of presentation, cognitive or functional deterioration, multiple co-morbidities and complex social care needs lead to significantly longer lengths of stay and higher re-admission rates.

The age standardised emergency admission rates among 65+ due to CVD in Waltham Forest from 2008/09 to 2011/12 show an increasing trend except for heart failure. Stroke showed a clear upward trend from 2008/09 to 2011/12.

Diabetes emergency admissions also increased among older people from 2008/09 to 2010/11. The reasons for diabetes related admissions in this age group are due in part to the complications of the disease but also related to medication-related complications e.g. hypoglycaemia and polypharmacy.

The ability of patients to manage their own disease, e.g. by administering their own insulin may become increasingly difficult, and the care of older people with diabetes needs to be appropriately personalised.

Falls

People aged 65+, living in Waltham Forest, are most at risk population for falls and this is discussed in more detail in Chapter 7.3.

⁴³⁶ Health and Social Care Information Centre (HSCIC).

⁴³⁷ Community Mental Health Profiles 2013.

⁴³⁸ Projecting Older People Population Information (POPPI).

Sensory disability

In 2011, Waltham Forest had 875 older people registered as blind or partially sighted and 65 as deaf or hard of hearing. The rates were significantly lower for those that were deaf or hard of hearing compared to national rates, however, those that were registered as blind were significantly higher than the national rates.⁴³⁹

Social care

Social care provides various services that promote wellbeing and support people and carers with dementia.

Evidence on better value for money could be achieved from current care spending by re-focusing resources in schemes that promote healthy lifestyles and adoption of best practice models in the Partnership for Older People Projects (POPPs).

Reducing emergency admissions continues to be a local priority and there is a body of evidence from UK pilots to reduce this. These include virtual wards, self-care, rehabilitation, re-enablement and assistive technologies. Reducing risk of readmission, delaying the need for residential care and promoting independence and quality of life are other demonstrated outcomes.

Supported Housing is part of the Waltham Forest joint prevention strategy, for older people including sheltered housing and extra care housing which plays a key role in enabling older people to remain living independently and promoting health and wellbeing.

End of Life Care

End of Life Care is discussed in more detail in chapter 7.5.

Recommendations

Mental health, wellbeing and dementia

1. Continue to work across health and social care with active involvement of older people and the third sector to finalise and implement evidence-based public mental health strategy with particular emphasis on hard to reach and vulnerable groups.
2. Use public awareness campaign around dementia to improve diagnosis, early intervention and address stigma and make people aware of the local support options available – use of national campaigns such as World Mental Health Day and Dementia Awareness week are potential opportunities.
3. Further strengthen the services aimed at reducing isolation considering the high percentage of people 75+ living in isolation and the strong evidence base to improve mental wellbeing.
4. Strengthen the post stroke spasticity service provision through the proposed local care pathway.
5. Use public awareness campaign around dementia to improve diagnosis, early intervention and sign up to time to change campaign to address stigma and make people aware of the local support options available – use of national campaigns such as World Mental Health Day and Dementia Awareness week are potential opportunities.
6. Continue to work on improving the dementia care pathway to provide holistic care integrating health, social care and voluntary sector, with particular focus on older people based on prevention, shifting unscheduled into scheduled care and right time right person right place which are critical parts to slow down/reverse the increasing trend in emergency admission rates.

⁴³⁹ Older People's Health and Wellbeing Atlas.

7. Better engagement of older people and carers and tailoring of local services to groups who currently not having equitable access are including BAME, most deprived communities and people living alone with dementia as evidence indicates these groups experience relatively more difficulties in accessing services.
8. Further strengthen the integrated care model (ICM) to focus more on older people and improve data sharing of primary, acute and social care data to inform more effective use of health and social care services commissioned locally as they have a higher prevalence of these conditions.
9. Training of all front line staffs including Social workers, Care Homes, Hospital staff who have regular contact with people with dementia on specific communication needs of this group of patients.
10. Further strengthen the number of dementia advisers to improve access to people with dementia as current capacity is inadequate to meet the existing need.
11. Consider incorporating severe mental illnesses in the integrated care model as this group of patients in Waltham Forest experience above average risk of emergency admissions.
12. Explore commissioning of specialist liaison mental health teams (with emphasis on older people) to work in acute settings similar to RAID model as these effective in delivering value for money and improving clinical and patients outcomes.

Recommendations on visual impairment

- Develop a vision strategy for Waltham Forest to align with the national strategy
- Plan and implement awareness raising campaigns using appropriate media that is specific to the target at-risk groups
- Explore using community-based health trainers can help disseminate eye health messages at a grassroots level
- Implement professional development and training including can help service-delivery staff supports at-risk groups with access to culturally sensitive health campaigns promoting eye health
- Structural changes in service delivery, including data recording and monitoring, and tracking patients along care pathways.

Demographics of older people in Waltham Forest

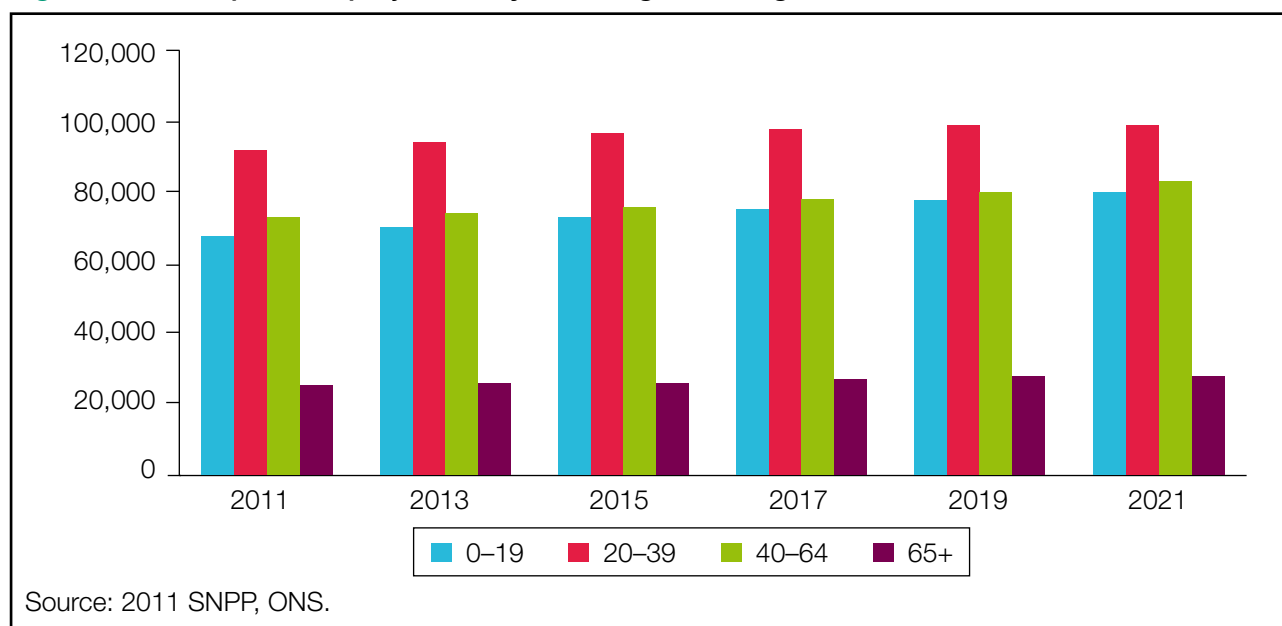
This chapter provides a picture of older people aged 65 and over and their most significant health and social care needs.

Socio-demographic profile and projections of older people

In London, the number of people over the age of 65 is increasing at a faster rate than other age groups, and is expected to reach 1 million by 2026. The 2011 Census reported that there are 259,742 people within Waltham Forest and 25,770 (9.92%) are aged 65 and over. This population is projected to rise from 25,770 in 2011 to 28,386 by 2021 (Figure 8.1).⁴⁴⁰

⁴⁴⁰ Office for National Statistics (ONS) – Sub national population projections 2011 Interim Census-based.

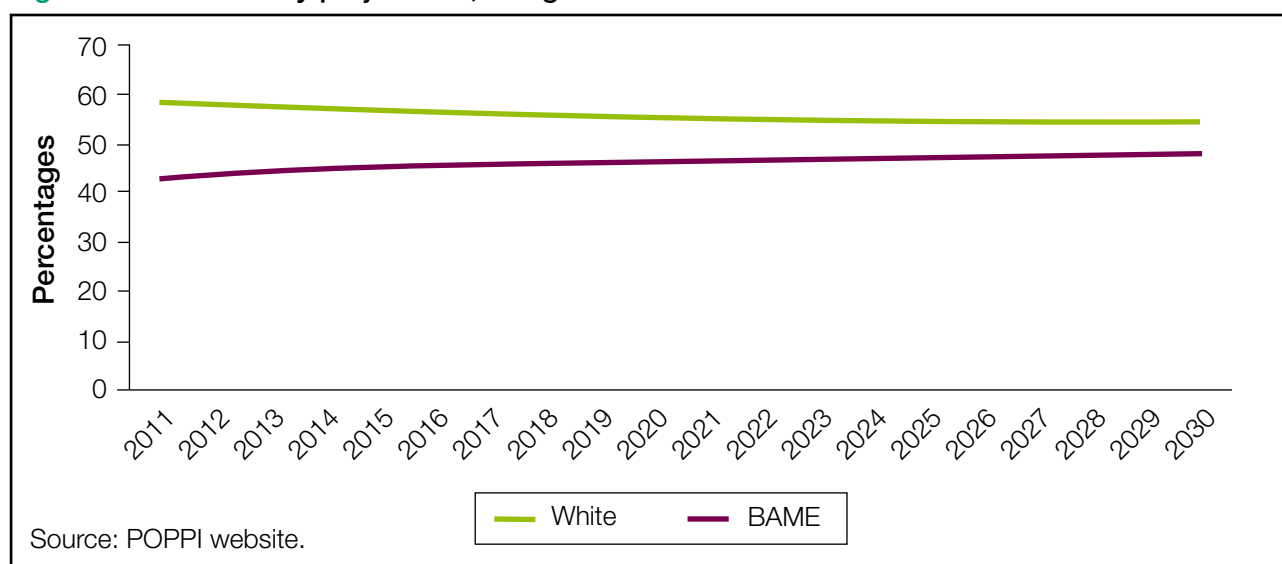
Figure 8.1 Population projection by broad age banding



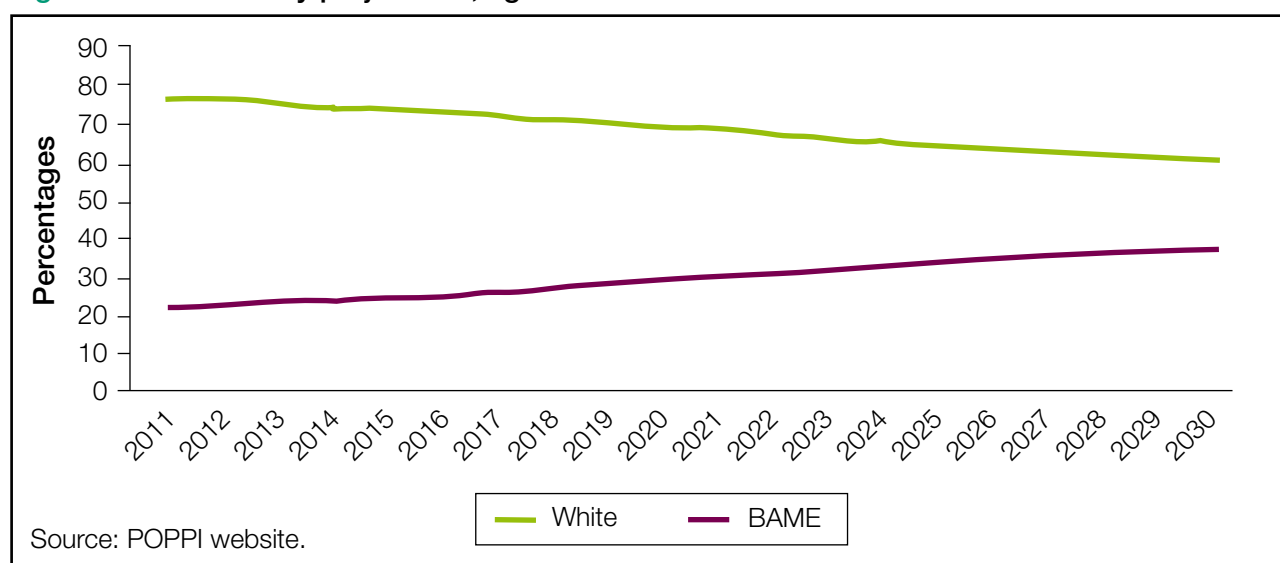
In Waltham Forest the projected BAME population of 65 years and over for 2021 will be 11,115, up from the current population of 6,912⁴⁴¹.

The rate of growth among BAME groups in Waltham Forest is much faster among older people compared to their White counterparts as shown in Figures 8.2 and 8.3. This has implications for with rising associated specific health and social care needs.

Figure 8.2 Ethnicity projections, all ages



⁴⁴¹ Greater London Authority (GLA) 2012 Round Ethnic Group Projections – SHLAA.

Figure 8.3 Ethnicity projections, ages 65+

Risk factors

Deprivation affecting older people

Waltham Forest continues to be one of the most deprived boroughs in England. In terms of the overall measure of multiple deprivation (IMD 2010) Waltham Forest ranks 15th most deprived among the 326 local authorities in England.

Deprivation affecting older people in Waltham Forest is equal to the London average but is worse than the England average⁴⁴². Higher levels of deprivation are found in the middle and southern wards of Higham Hill, Leyton, Cann Hall, Cathall, Hoe Street, Markhouse, William Morris, Forest and Lea Bridge.

The vast majority (85.5%) of people aged 65+ live within wards with the highest level of deprivation (Quintile 5 and Quintile 4).

Home and neighbourhood

According to a survey in 2011, 72.1% of people over 65 in Waltham Forest were satisfied with their homes and neighbourhoods, compared to London (77.1%) and national (83.9%).

- Almost 50% of people aged 75 and over live alone⁴⁴³
- Of pensioner households 20.3% are considered to live in non-decent homes, mainly due to lack of thermal comfort. The index of excess winter deaths to people over the age of 65 in Waltham Forest (25.9) is higher than London (21.8) and England (20.9).⁴⁴⁴ Also, the percentage of over 65's who assess their general health as 'not good' in Waltham Forest is 24.7% compared to London (22.3%) and England (21.5%).⁴⁴⁵

⁴⁴² JSNA Older People Chapter 2011_12 (Spine chart).

⁴⁴³ Projecting Older People's Population Information (POPPI).

⁴⁴⁴ Older People's Health and Wellbeing Atlas.

⁴⁴⁵ Health Needs Assessment Toolkit.

Housing tenure among those aged 65 and over is shown in Table 8.1 below.

Table 8.1 Ownership of housing and other living accommodation among 65+ in Waltham Forest

	65-74 years	75-84 years	Over 85 years
Owned	67.26%	59.86%	52.18%
Rented from Council	16.69%	20.32%	21.43%
Other social rented accommodation	8.27%	9.56%	11.67%
Private rented or living rent free	7.78%	10.25%	14.72%

Source: POPPI⁴⁴⁶ website.

What are effective interventions?

Housing adaptations and practical support are identified as some of the high impact interventions for older people to stay healthier, more independent and more socially included for longer⁴⁴⁷.

What is being done locally to improve housing?

Supported housing for older people in Waltham Forest including extra care housing and sheltered housing play a key role in enabling older people to remain living independently in the community. This initiative is an integral part of the Joint Prevention Strategy⁴⁴⁸. Extra Care housing is a priority in Waltham Forest's Supporting People strategy 2010–15 and a key component of the Continuum of Care.

Extra Care services provide safe and accessible housing with 24/7 holistic care and support for older people with dementia or with learning disabilities. This enables older people to maintain independence in the community in line with user's choices and promotes wellbeing. Outcomes monitoring has shown that Extra Care services are decreasing demand on residential care and helping to avoid non-elective hospital admissions. There are currently 857 sheltered housing units and 252 extra care units in Waltham Forest, with support commissioned at an annual contract value of £1.48 million. The local authority is aiming to increase extra care provision by an additional 75 units by 2015.

⁴⁴⁶ <http://www.poppi.org.uk/>

⁴⁴⁷ http://www.kingsfund.org.uk/publications/appendices_to.html

⁴⁴⁸ Joint Prevention Strategy in Waltham Forest (2011).

It is important to note that the indicator 'permanent admissions to residential or nursing home care' in Waltham Forest has improved significantly to 404/100,000 in 2011/12 and is lower than the national average of 705.9/100,000.

National Service Framework (NSF) for older people 2001

This NSF for older people was the first ever comprehensive strategy to ensure fair, high quality, integrated health and social care services for older people. It was a ten year programme of action linking services to support independence and promote good health, specialised services for key conditions, and culture change so that all older people and their carers are always treated with respect, dignity and fairness. The NSF covers rooting out discrimination; person-centred care, intermediate care, general hospital care; stroke; falls; mental health including dementia; and promotion of a healthy and active life including medicine management. The NSF continues to be relevant and provides the focus for the following discussion on mental health including dementia, stroke, falls and End of Life care to inform commissioning priorities for older people in Waltham Forest.

Local picture

The following sections describe the most significant conditions in Waltham Forest set out in the NSF for older people. Each section begins with a definition of the condition and a description of the risk factors, followed by a comparison of Waltham Forest results with other areas.

Life expectancy at age 65 and associated inequalities:

- In 2010–12, life expectancy at age 65 was 18.7 years for males, similar to England (18.56 years) and London (18.9 years) for males and 21.6 years for females England (21.1 years) and London (21.7 years).⁴⁴⁹

Table 8.2 sets out the current and predicted numbers of people 65+ with limiting long-term illnesses.

Table 8.2 Current and projected number of people aged 65+ with limiting long-term illnesses

Limiting long-term illness	2011	2015	2020	2025	2030
Caused by heart attack	1,132	1,158	1,193	1,290	1,427
Caused by a stroke	533	549	566	613	676
Caused by bronchitis/emphysema	389	398	410	443	492
Total Number*	11,830	12,086	12,579	13,546	14,936

*Total number is more than the cumulative sum of the 3 conditions as only 3 main LLTI conditions are mentioned here.

Dementia

Dementia is a disorder of the brain associated with many clinical features including impairment of memory, learning, judgement, language and emotions, which affects the ability to carry out activities of daily living. It is chronic and usually progressive. It is rare in people under 60 years of age, but increases in prevalence in older age groups^{450, 451}.

There are many different types of dementia, including Alzheimer's disease (the most common), Vascular dementia, Lewy Body dementia and Parkinson's disease⁴⁵².

⁴⁴⁹ Office for National Statistics (ONS), Life Expectancy 2010–12.

⁴⁵⁰ Jaccques A. and Jackson G.A. Understanding Dementia. Third Edition. Churchill Livingstone, 2000. P3, 4.

⁴⁵¹ Carter P.J. Lippincott's text book for Nursing Assistants: A humanistic approach to care giving. Second Edition. Lippincott Williams and Wilkins, 2008. P.724.

⁴⁵² Compton M. T. and Kotwicki R. J. Responding to Individuals with Mental Illness. Jones and Bartlett, 2006. P.110.

Known risk factors include female sex, lower level of education, history of severe head injury and depression⁴⁵³. Cardiac risk factors including diabetes and hypertension are also risk factors for dementia, as is stroke disease.

One in 14 people over 65 years of age and one in six people over 80 years of age have some form of dementia. In England, there were 665,065 dementia patients in 2012.⁴⁵⁴ It is estimated that by 2021 there will be one million people with dementia in the UK with an expected rise to over 1.7 million by 2051⁴⁵⁵. Same no change. The number of people with dementia for London in 2012 was 66,043 with a projected rise to 78,580 by 2020⁴⁵⁶. In Waltham Forest, the number of people with dementia is expected to increase by 5.1% by 2020 (from 1,843 in 2012 to 1,937 in 2020).⁴⁵⁷

The prevalence of dementia in Waltham Forest calculated using all age GP list size as the denominator in 2011/12 was 0.3%. This was lower than that for England (0.5%) and for London (0.4%).⁴⁵⁸

From 2009/10 to 2010/11 the detection rate for dementia increased by 5.1%, placing Waltham Forest at the top for detection rate and the highest increase across London. The increase in detection rate was higher than England (1.8%) and London (1.6%).

High risk groups for dementia

People with learning disabilities (PLD) have a higher risk of developing dementia compared to the general population, with a significantly increased risk for people with Down's syndrome and at a much earlier age. Waltham Forest has 110 people with Down's syndrome, 34 of whom are between the ages of 45–64.⁴⁵⁹ Please delete if necessary but I could not find data of people with Down's and dementia.

The increase in BAME groups in Waltham Forest will mean increasing numbers who are more at risk of developing vascular dementia as they have a higher prevalence of diabetes and hypertension. It is estimated that in the BAME groups in the UK there are approximately 15,000 people living with dementia (Department of Health 2009). It is also estimated that by 2021, 41.1% of the population aged over 65 years will be from BAME groups. This increase in the number of older BAME people in the UK is likely to lead to an increased need for dementia services. Figures remain approximate because prevalence of dementia amongst BAME groups in the UK is difficult to calculate accurately. No large-scale studies yet exist with sufficient numbers of BAME people to allow comparison between the various types of dementia across different ethnic groups⁴⁶⁰.

Quality of Dementia Care

Table 8.3 summarises DEM2 QOF achievements by practices and clinical commissioning groups in Waltham Forest, 2011/12. All 46 practices achieved the target for DEM 2*.

⁴⁵³ Kelsey J. E., Newport D.J. and Nemeroff C.B. Psychopharmacology for Mental Health Professionals. Wiley-Liss, 2006. P.287.

⁴⁵⁴ Projecting Older People's Population Information (POPPI) and PANSI.

⁴⁵⁵ Demography of Dementia. Alzheimer's society. Last updated April 2012. Available from: http://alzheimers.org.uk/site/scripts/documents_info.php?documentID=412

⁴⁵⁶ POPPI.

⁴⁵⁷ Projecting Older People's Population Information (POPPI).

⁴⁵⁸ Health and Social Care Information Centre (HSCIC).

⁴⁵⁹ Projecting Older People's Population Information (POPPI).

⁴⁶⁰ Moriarty J, Sharif N and Robinson J. Black and minority ethnic people with dementia and their access to support and services, Social Care Institute for Excellence (SCIE) 2011.

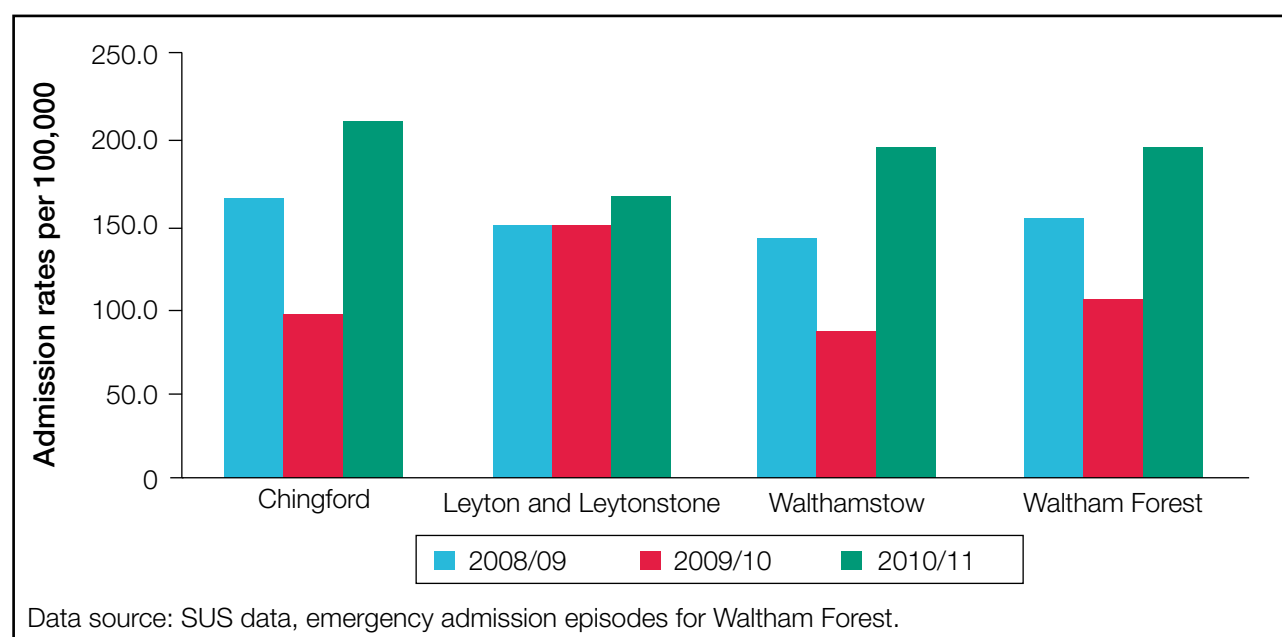
Table 8.3 Summary of QOF achievements on dementia in Waltham Forest (2011/12)

Indicator	National target	PCT		No of practices achieving the target with exceptions
		with exceptions	without exceptions	
DEM2*: The percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months	60%	80.2%	75.7%	46

Source: Health and Social Care Information centre (HSCIC) QOF 2011/12.

In 2011/12, there were 8,868 emergency admissions among people aged 65+. The emergency admission rate in Waltham Forest was higher than the national rate in 2011/12.⁴⁶¹

As shown in Figure 8.4, the emergency admission rates for adults above 65 years of age in Waltham Forest and in the three GP consortia increased from 2008/09 to 2010/11. Chingford recorded the highest number of admissions, while Leyton and Leytonstone recorded the lowest in 2010/11.

Figure 8.4 Dementia emergency admission rates among 65+ by locality in Waltham Forest: 2008/09 to 2010/11

Despite recording a lower registered prevalence, the rates for emergency admission episodes for Dementia in Waltham Forest from 2011/12 were higher than the national rates.

⁴⁶¹ Older People's Health and Wellbeing Atlas.

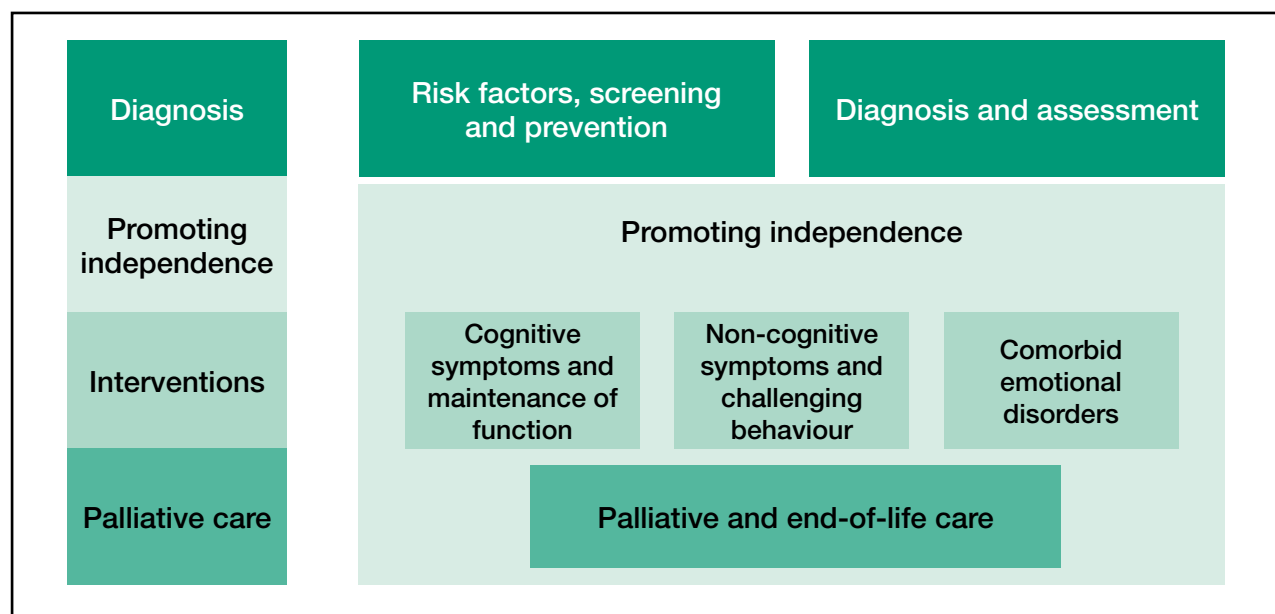
What are effective interventions?

National guidance

The NSF Older People 2001 Standard 7 and a number of NICE publications provide evidence-based interventions for dementia as summarised below:

Figure 8.5 sets out pictorially what the guideline covers; i.e., risk factors, screening and prevention, early identification and diagnosis, promoting independence and palliative and end of life care. The guideline covers people of all ages with all forms of dementia including mild, moderate and severe.

Figure 8.5 NICE clinical guideline 42 (2006): Dementia: supporting people with dementia and their carers in health and social care



NICE technology appraisal 217 (November 2006) last updated in March 2011 – provides guidance on the use of the acetylcholinesterase inhibitors donepezil, rivastigmine and galantamine and another drug, memantine, for the treatment of Alzheimer's disease. This guidance is expected to inform current prescribing practice.

NICE quality standard on dementia⁴⁶² (June 2010) defines clinical best practice in dementia care with 10 statements and relevant quality measures. The standard describes markers of high-quality, cost effective care that, when delivered collectively, should contribute to improving the effectiveness, safety, experience and care for adults with dementia.

There are quality measures of best practice for each quality statement which can be used to benchmark the local performance to identify priorities for improvement of care. While not mandatory, using these quality standards demonstrates good practice.

⁴⁶² <http://www.nice.org.uk/guidance/qualitystandards/dementia/dementiaqualitystandard.js>

Evidence on prevention of dementia

The risk factors for vascular dementia are high blood pressure, obesity and stroke, most of which are amenable to prevention. Interventions aimed at preventing smoking, excessive alcohol use, diabetes and raised cholesterol are effective initiatives to reduce the risk of vascular dementia.

Vascular dementias are potentially preventable and cases of Alzheimer's disease with vascular components are becoming increasingly recognized. Cerebrovascular risk factors in particular hypertension are influential in considering treatment and prevention of vascular dementia and cognitive dysfunction in the elderly.

Clinical trials on calcium channel blockers (CCBs) specifically found a preventive effect on Alzheimer's Disease dementia. The aetiology for dementia is most often a mix of Alzheimer's Disease and CVD, the relevance of antihypertensive (AHT) treatment for dementia prevention is likely to be greater than previously acknowledged⁴⁶³. Multiple lines of evidence suggest that enhanced and better management of hypertension could be effective for the prevention of either Alzheimer's Disease dementia or vascular aetiology⁴⁶⁴.

What is being done locally to address dementia?

A joint dementia strategy was developed and agreed in 2011 to align with the national dementia strategy. Progress in delivering some of the initiatives includes

- Training of Acute Care Staff (WXUH) through London Commissioning for Quality and Innovation (CQUIN) programme
- Creating public awareness with particular emphasis on hard to reach communities through active engagement
- Establishment of a memory clinic and recruitment of an Admiral Nurse.

A number of strategic initiatives are being implemented locally to address the risk factors for dementia, including the smoking strategic plan and alcohol harm reduction strategy in Waltham Forest. However, it is important to pay more emphasis on older people in these local initiatives as a specific group who are less likely to participate in lifestyle initiatives due to a range of factors.

The Alzheimer's Society's Dementia Adviser (DA) service signposts and facilitates access to services and support to ensure people have the help and care they need. The service supports recommendation 4 of the National Dementia Strategy for England (Dept of Health 2009). Each DA can support a caseload of 200 per year. The service was co-designed by people with dementia and their carers who said they would benefit from sitting down face-to-face with someone shortly after diagnosis to plan for the journey ahead and that information should be communicated in an informal and friendly way.

Views of stakeholders on dementia

A workshop involving stakeholders was held to discuss and agree any service developments required to improve dementia care locally. A summary of the gaps are listed below:

- Under-diagnosis of dementia
- [Unintentional] exclusion of some key groups in the community from the existing pathway; due to language barriers, a stigma around dementia (particularly in some cultures) which holds people back from getting diagnosed, financial difficulties for families who have income just above the cut off for support but who are still struggling to afford care, and a lack of flexibility around service provision to cater for people living alone with dementia
- Lack of public knowledge/awareness around dementia (what to look for as symptoms), misperceptions about it (leading to stigma) and lack of awareness of the support services available

⁴⁶³ M Valenzuela, M Esler, K Ritchie and H Brodaty. Antihypertensives for combating dementia? A perspective on candidate molecular mechanisms and population-based prevention, *Transl Psychiatry* (2012) 2, e107, doi:10.1038/tp.2012.28 and 2012 Macmillan Publishers Limited All rights reserved 2158-3188/12.

⁴⁶⁴ Lis CG, Gaviria M. Vascular dementia, hypertension, and the brain, *rol Res.* 1997 Oct;19(5):471-80.

- Lack of knowledge and skills of key people working with dementia – including GPs, in Care Homes, in Hospital etc
- Capacity issues in existing services (particularly in the voluntary sector) – many services already have waiting lists, or are at least near capacity
- Little on offer once people are diagnosed in the early stages of dementia and a lack of options in community services beyond day care
- Lack of links and the sharing of information between services in primary, social services and the voluntary sector – with some notable exceptions where collaboration between individual services is working very well.

Mental health disorders among older people

Please refer to the chapter (5.5) on mental health for a full discussion. A summary of issues affecting older people is provided below.

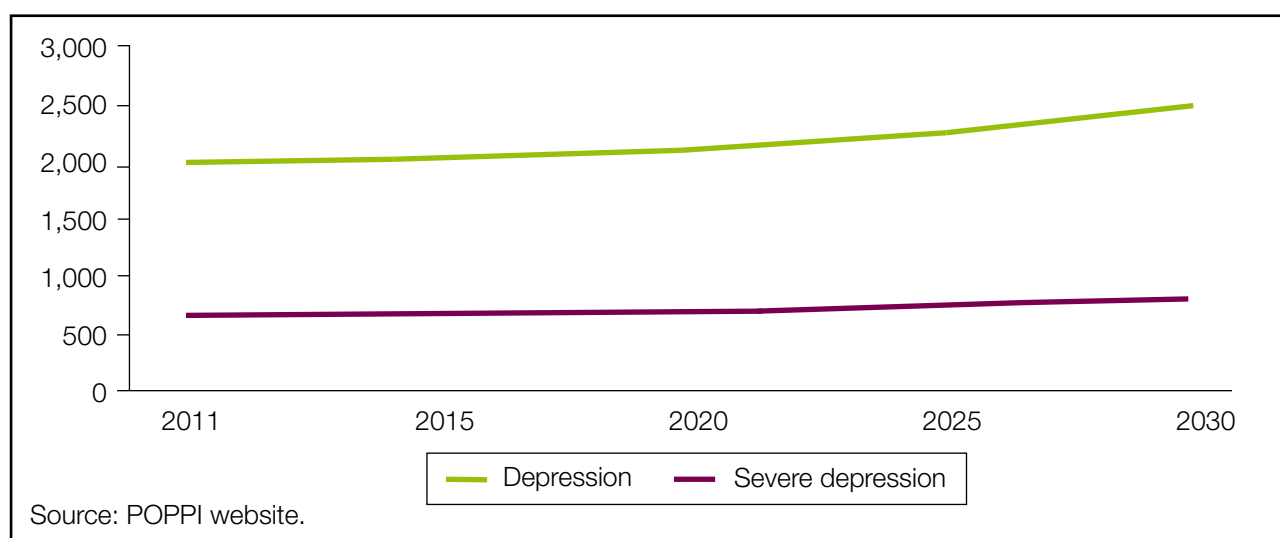
Older people with mental health problems are more likely to end up in institutional care than other older people. They also recover less well from physical problems and illness and are more likely to be the victims of abuse.

Depression

Older people have a higher prevalence of depression with almost 12% of people over 65 estimated to have depression.⁴⁶⁵ In people aged 75 or over, depression may be associated with a metabolic imbalance resulting from poor diet and sleep and can suppress immunity, increasing susceptibility to infections.

Figure 8.6 shows that the number of people with depression and severe depression in Waltham Forest is expected to increase gradually up until 2020. From 2020 a rapid increase in depression is predicted, while this rapid increase is not predicted for severe depression.

Figure 8.6 Current and projected numbers 65 + to have depression and severe depression



⁴⁶⁵ Projecting Older People's Population Information (POPPI).

What are effective interventions?

The NSF for Older People 2001 highlighted explicit discrimination in mental health services where the organisational division between mental health services for adults of working age and older people has resulted in the development of a system that offers a range of services that differs for each of these groups.

Discrimination, participation in meaningful activities, relationships, physical health, and poverty have been found to be particularly important factors influencing the mental health and wellbeing of older people⁴⁶⁶. A Department of Health (2010) publication identified⁴⁶⁷ the following effective interventions for the promotion of wellbeing specifically among older people:

- psychosocial interventions
- high social support before and during adversity
- prevention of social isolation
- multi-agency response to prevent elder abuse
- walking and physical activity programmes
- learning and volunteering.

Rapid Assessment Interface and Discharge (RAID) model⁴⁶⁸ in acute setting

Rapid Assessment Interface and Discharge (RAID) psychiatric liaison service operates in City Hospital, Birmingham and is an award-winning service that offers comprehensive mental health support, available 24/7, to all people aged over 16 within the hospital. Savings were generated from reduced bed use among elderly patients. The service offers additional potential savings as a result of the reduction in discharges of elderly patients to institutional care rather than their own homes.

The RAID model:

- Offers a comprehensive range of mental health specialities within one multi-disciplinary team, for all aged 16+ to be assessed, treated, signposted or referred appropriately
- Operates 24 hours a day, 7 days week
- Emphasises rapid response, with a target time of one hour within which to assess referred patients who present to A&E and 24 hours for seeing referred patients on the wards
- Aims to meet the mental health needs of all adult patients in the hospital
- Provides formal teaching and informal training on mental health difficulties to acute staff throughout the hospital
- Put emphasis on diversion and discharge from A&E and on the facilitation of early, but effective, discharge from general admission wards.

The top six reasons for referral to RAID were: deliberate self-harm 27.6%; depression 16.2%; cognitive impairment, confusion and dementia 13.6%; alcohol misuse 12.5%; suicidal ideation 10.1%; and psychosis 8.4%.

⁴⁶⁶ <http://www.nice.org.uk/nicemedia/live/11671/41268/41268.pdf>

⁴⁶⁷ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114774

⁴⁶⁸ Parsonage M and Fossey M, Mental Health Network NHS Confederation, London School of Economics. Report on Economic evaluation of a liaison psychiatry service (2010).

An independent economic evaluation indicated that the incremental cost of RAID (i.e. the additional cost of the service compared with its predecessor) was around £0.8 million a year, while it was estimated on conservative assumptions that RAID generated incremental benefits in terms of reduced bed use valued at £3.55 million a year.

What is being done locally to address mental health in older people?

A Waltham Forest joint mental health strategy is being finalised, which has an emphasis on older people.

The difficulty in obtaining accurate and timely data relating to community service provision on mental health services (e.g. early intervention) for specific population groups in Waltham Forest remains a key challenge in understanding the adequacy in service capacity to meet local needs. This is a key requirement to inform interventions to reduce the increasing trend in emergency admissions.

Variation in quality of primary care among people with SMI could lead to emergency admissions.

Cardio vascular diseases among older people

Please refer to the chapter (5.3) on CVD for a full discussion. A summary of issues affecting older people is provided below.

Stroke among older people

Stroke is the single largest cause of adult disability. Nationally, about half of people affected with stroke are dependent on other people for help with everyday activities. A third of people who have a stroke are left with long-term disability. The effects can include aphasia, physical disability, loss of cognitive and communication skills, depression and other mental health problems.

A transient ischaemic attack (TIA) also referred to as a 'mini stroke' is a set of symptoms similar to a stroke, but which last less than 24 hours. It is due to a temporary lack of blood to a part of the brain. In most cases, a TIA is caused by a tiny blood clot that becomes stuck in a small blood vessel (artery) in the brain. This blocks the blood flow and a part of the brain is starved of oxygen for just a few minutes and soon recovers. Timely treatment of TIA can prevent a person developing a full-blown attack of stroke.

High blood pressure and atrial fibrillation (irregular heart rhythm) are significant risk factors for TIA and stroke. Therefore reducing these risk factors among people is important.

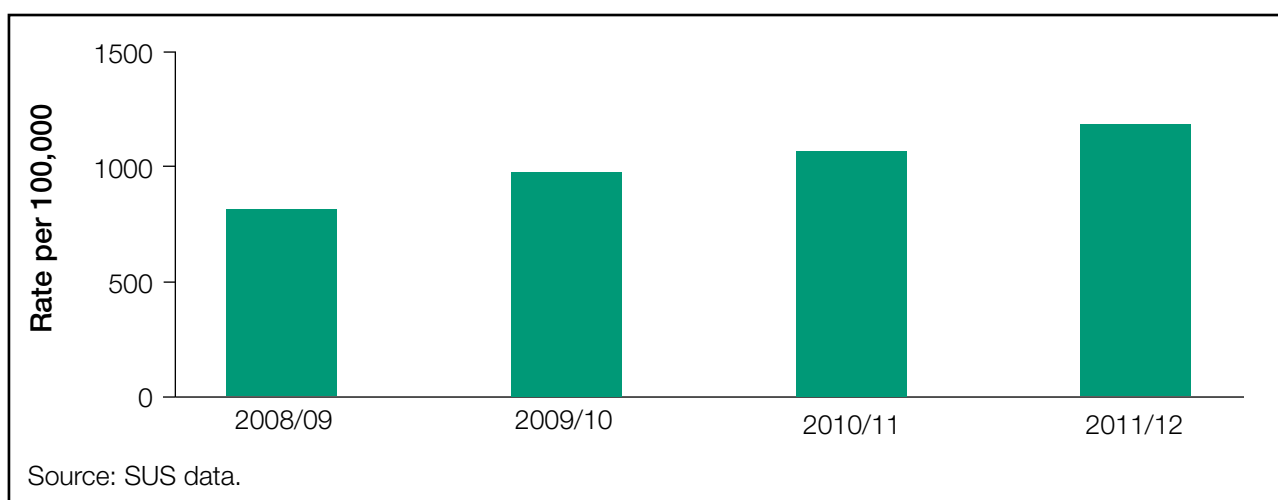
11% of deaths are the result of stroke nationally.

20 to 30% of people who have a stroke die within a month. Stroke is the largest cause of disability in the UK, and the third commonest cause of death (after heart disease and cancer). Most cases occur in people aged over 65. Each year about one in 100 people over the age of 75 have a stroke.

Local picture

There were 2,666 with registered with stroke in Waltham Forest and the prevalence was 0.9% in 2011/12, much below the estimated prevalence.

Figure 8.7 shows an increasing trend in the age standardised stroke admission rate from 2008/09 to 2011/12. Under detection and variation in management and patient factors are likely to contribute to this trend.

Figure 8.7 Age standardised admission rate for stroke for people over 65 in Waltham Forest

Visual impairment

Loss of vision can occur suddenly or develop gradually over time. Vision loss may be complete (involving both eyes) or partial, involving only one eye or even certain parts of the visual field. Vision loss is different from blindness that was present at birth. Vision loss can also be considered as loss of sight that cannot be corrected to a normal level with eyeglasses. The causes of loss of vision are extremely varied and range from conditions affecting the eyes to conditions affecting the visual processing centers in the brain. Impaired vision becomes more common with age. Common causes of vision loss in the elderly include diabetic retinopathy, glaucoma, age-related macular degeneration, and cataracts. Uncontrolled high blood pressure also can lead to visual impairment.

Definition of visual impairment

In the UK, an individual may be registered as blind if their visual acuity is 3/60 or worse (can see at three metres, or less, what a person with normal vision can see at 60 metres); or 6/60 if your field of vision is very restricted and you do not have full range of sight. An individual may be registered partially sighted if their visual acuity is between 3/60 and 6/60 with a full field of vision, or up to 6/18 (18 is the number of the fourth line down on the Snellen eye chart) if your field of vision is very restricted⁴⁶⁹. The legal definition of blindness in the UK is included in the National Assistance Act of 1948 which says that 'a person can be certified as blind if they are so blind that they cannot do any work for which eyesight is essential'⁴⁷⁰.

Sight loss in the UK is estimated to double over the next 40 years⁴⁷¹, which will have a significant impact on the UK's health and social care system and damage the quality of life for millions of people.

⁴⁶⁹ Royal National Institute of the Blind (RNIB) web site. Retrieved May 10, 2005 from http://www.rnib.org.uk/xpedio/groups/public/documents/PublicWebsite/public_rnib003702.hcsp

⁴⁷⁰ RNIB, 2006. Feeling great, looking good. UK: RNIB.

⁴⁷¹ Access Economics, 2009. Future sight loss UK: The economic impact of partial sight and blindness in the UK adult population. UK: RNIB.

Other support for examining sight loss

RNIB, working alongside partners in the sight sector, have produced a range of materials and resources to support local authorities. Resources include guidance and a series of factsheets on how sight loss relates to particular public health priorities, and a data tool.

The data tool is a free resource which provides key statistics on a range of eye health and sight loss topics, broken down to a local authority area. The data includes, the numbers of people understood to be living with sight loss and future predication.

For further information on these tools is available at <http://www.rnib.org.uk/getinvolved/campaign/resources/national/Pages/public-health-toolkit.aspx>

Focusing on at-risk communities

Although sight loss can affect anyone at any time, several groups are at an increased risk of losing their sight unnecessarily. South Asian communities have an increased risk of diabetes and consequently diabetic eye conditions, including diabetic retinopathy and African and African-Caribbean groups have an increased risk of developing glaucoma⁴⁷².

In addition, people living in socio-economic deprivation are less likely to access primary eye care services and are therefore at a greater risk of avoidable sight loss⁴⁷³.

The economic impact of sight loss

A recent report concluded that the annual cost of sight loss in the UK adult population is £22 billion, including direct and indirect health care costs, the loss of disability-free years and the loss of life due to premature death associated with sight loss⁴⁷⁴.

The wider impact of sight loss

People with sight loss are three times more likely to suffer depression⁴⁷⁵ and are at an increased risk of falls⁴⁷⁶. Late diagnosis of eye conditions causes additional health complications that put extra strain on the UK's health and social care system.

Government commitment to tackling avoidable sight loss

There is increasing commitment from governments across the UK to integrate eye health into public health strategies.

In England, the urgent need to tackle avoidable sight loss has been recognised in the Public Health Outcomes Framework, launched in January 2012⁴⁷⁷. This aspirational framework will encourage local authorities, in partnership with Health and Wellbeing Boards, to demonstrate improvements in eye health outcomes.

These opportunities provide eye health professionals with an opportunity to work collaboratively with public health specialists and commissioners to help ensure eye health is given an increased priority.

⁴⁷² Campbell, Sanderson and Robertson, 2010. Poor vision and falls. British Medical Journal, 340, 1313–1314.

⁴⁷³ Dickey *et al.*, 2007. Utilisation of eye-care services: An examination of the effect of Scotland's free eye examination policy. Scotland: University of Aberdeen.

⁴⁷⁴ Campbell, Sanderson and Robertson, 2010. Poor vision and falls. British Medical Journal, 340, 1313–1314.

⁴⁷⁵ Evans, Fletcher and Wormald, 2007. Depression and anxiety in visually impaired older people. Ophthalmology, February 2007, 283–288.

⁴⁷⁶ Campbell, Sanderson and Robertson, 2010. Poor vision and falls. British Medical Journal, 340, 1313–1314.

⁴⁷⁷ Public Health Outcome Framework 2012.

Evidence indicates that the following interventions could help reduce eye health inequalities:

1. Awareness raising campaigns are most effective in media that is specific to the target at-risk group.
2. Community-based health trainers can help disseminate eye health messages at a grassroots level.
3. Professional development and training including can help service-delivery staff support at-risk groups with access to culturally sensitive health campaigns promoting eye health.
4. Structural changes in service delivery, including data recording and monitoring, and tracking patients along care pathways.

What needs to be included in awareness raising campaigns

Explain that eye examination attendance should not be symptom-led. By explaining to customers that an eye examination is not just about glasses, but is also an important measure in assessing both general health and eye health, and detecting early onset eye disease, you could help change the current culture of symptom-led attendance for eye examinations. This will increase the number of people who attend a routine eye examination and ultimately ensure that more eye conditions are detected in the early stages, where treatment will be most effective.

Educate customers about eye health

People are not aware of the risk factors that contribute to unnecessary sight loss and at-risk groups do not know they are at an increased threat of sight loss. Therefore it is important to educate patients about the actions they can take to help protect their eye health:

- **Regular eye examinations** – encourage your patients to have their eyes examined at least once every two years, even if there is no change in their vision
- **Stop smoking** – smoking doubles the risk of developing AMD, the UK's leading cause of sight loss⁴⁷⁸
- **Healthy diet and weight** – eating a diet low in saturated fats, but rich in green leafy vegetables such as spinach and broccoli may help protect against cataracts and AMD. A balanced diet can also help customers maintain a healthy weight: obesity can increase the risk of developing diabetes, which in turn could lead to sight loss⁴⁷⁹
- **Protection from UV radiation** – wearing sunglasses can protect the eyes from the UVA and UVB rays in sunlight, which can increase the risk of cataracts⁴⁸⁰
- **Protective goggles** – DIY and sport (especially racquet-based sports) because thousands of eye related injuries each year.

Waltham Forest Vision Strategy group

Vision Strategy group identified the need to develop a local strategy and action plan to align with the 'UK Vision Strategy'. This strategy is expected to include the vision for Waltham Forest, and objectives together with evidence-based commissioning priorities reflecting the local needs (socio demographics, data on visual impairment etc.). The low employment rate amongst visually impaired people has been highlighted. The strategy development needs to involve the service users, carers, Local Authority Sensory Team, CCG, Whipps Cross eye Treatment Centre and the voluntary sector servicing visually impaired people.

⁴⁷⁸ Evans, Fletcher and Wormald, 2005. 28,000 cases of AMD causing visual loss in people aged 75 years and above in the United Kingdom may be attributable to smoking. *British Journal of Ophthalmology*, 89, 550–553.

⁴⁷⁹ RNIB, 2006. Feeling great, looking good. UK: RNIB.

⁴⁸⁰ West *et al.*, 1998. Sunlight exposure and risk of lens opacities in a population-based study. *JAMA*, 280 (8), 714–718.

What are effective interventions to improve health among older people?

A policy paper (August 2010), 'The billion dollar question': embedding prevention in older people's services' recognised the dearth of strong evidence on preventive services. The paper used the available evidence to identify ten 'high impact changes' with regard to prevention in older people's services:

- promoting healthy lifestyles (primary prevention)
- vaccination (primary prevention)
- screening (primary/secondary/tertiary prevention)
- falls prevention (primary/secondary/tertiary prevention)
- housing adaptations and practical support (primary/secondary/tertiary prevention)
- telecare and technology (secondary/tertiary prevention)
- intermediate care (secondary/tertiary prevention)
- re-ablement (secondary/tertiary prevention)
- partnership working (may have longer term impacts, but currently unknown)
- personalisation (may have longer term impacts, but currently unknown).

A whole system approach is strongly recommended with all stakeholders working in collaboration. If the current trend of need and demand continues among older people, current provision of services is unsustainable⁴⁸¹. This leads to the need to focus on two main approaches:

1. prevention of ill health and promotion of good health; and
2. reconfiguration of services to support people to live in a community setting as long as possible, avoid admission to hospital, and return to a community setting after discharge from hospital.

Healthy ageing

The World Health Organisation defines healthy ageing as 'the process of optimising opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality of life.'

Primary prevention actions to promote healthy ageing are, therefore, grounded in neighbourhoods and communities, affecting community and home life.

Ageing well interventions (listed below) promote wellbeing in later life while reducing the risk of admissions to acute and residential care. Interventions to prevent social isolation can improve wellbeing:

- Befriending results in reduced depression
- Volunteering opportunities are also associated with improved mental wellbeing, self-reported health and reduced depression
- Learning programmes also improve wellbeing in older people
- Addressing hearing loss is associated with improved quality of life
- Physical activity programmes can improve mental wellbeing and reduce mental illness
- interventions to promote household warmth are associated with improved mental health and reduced depression.

⁴⁸¹ <http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/20100218-underpressure-nationalstudy.pdf>

This approach is reflected in Standard 8 of the NSF, which is aimed at promoting health and wellbeing, to prevent or delay the onset of ill health and disability by encouraging people to live a healthy, active life.

Standard 3 of the NSF on Older People (2001) focused on intermediate care and integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living. This NSF promoting independence, advocated the increasing the number of intermediate care places and decreasing the number of care home places required which was then taken forward through 'Our Health, Our Care Our Say' and continues to be a commissioning priority locally.

Mental wellbeing among older people

Approximately 35% of patients with mental illness in the UK are over 65⁴⁸² while 25% of older people in the community have symptoms of depression requiring intervention (11% minor depression, 2% major depression)⁴⁸³. Furthermore, 20 to 25% of people with dementia also have major depression while 20–30% have minor or sub-threshold depression⁴⁸⁴. Early diagnosis and intervention benefit those affected by mental illnesses such as depression and dementia as well as their carers. Addressing underlying physical conditions is also important. Early treatment of dementia is effective and improves quality of life⁴⁸⁵.

Social prescribing: physical activity

The effectiveness of exercise in the treatment of clinical depression is well documented. Physical activity is associated with a reduced risk of depression and dementia later in life⁴⁸⁶.

Physical activity improves not only sub-threshold, mild and moderate depression and wellbeing, improved mental health and wellbeing in deprived communities, improved mental wellbeing of those with schizophrenia and improved mental health outcomes in older people.⁴⁸⁷

Comprehensive Geriatric Assessment (CGA)

CGA provides an evidence-based model for the provision of the co-ordinated multi-disciplinary care that older people with complex needs. The British Geriatric Society states that the NHS now need to invest time and effort to re-organise services around an evidence-based multi-disciplinary model of care for acute medical care of older people (British Geriatric Society (2012))⁴⁸⁸.

Additional examples have demonstrated effectiveness in reducing emergency admissions⁴⁸⁹:

- Health and social care service integration for older people via a care trust (Torbay Care Trust (2009)
- Integrated urgent care within general practice (Birchwood practice (Norfolk) ACAPON rapid Integrated assessment and care team (2009)
- Extended access hours intermediate care (Fife intermediate care project (2010)
- Integrated intermediate care within general support for older people response team (Partnerships for older people (POPP), Bradford, East Sussex and Brent case studies (2010)

⁴⁸² Healthcare Commission, Care Services Improvement Partnership, National Institute for Mental Health in England and Mental Health Services Act Commission. Count me in 2008: results of the 2008 national census of inpatients in mental health and learning disability services in England and Wales, [London]: Commission for Healthcare Audit and Inspection; 2008.

⁴⁸³ Craig R, Mindell J, editors. Health Survey for England 2005: health of older people. Leeds: The Information Centre; 2007.

⁴⁸⁴ [5] Amore M, Taqariello P, Laterza C, Savioa EM. Subtypes of depression in dementia. Arch Gerontol Geriatr 2007; 44(1): 23–33.

⁴⁸⁵ Banerjee S, Willis R, Matthews D, *et al.* Improving the quality of care for mild to moderate dementia: an evaluation of the Croydon memory service model. Int J Geriatr Psychiatry 2007; 0885–6230.

⁴⁸⁶ Department of Health 2009 Be Active Be Healthy: A plan for getting the nation moving http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094358

⁴⁸⁷ National Institute for Health and Clinical Excellence (2009) Depression: The Treatment and Management of Depression in Adults. NICE (<http://guidance.nice.org.uk/CG90>).

⁴⁸⁸ Office for National Statistics (ONS) – Sub national population projections 2011 Interim Census-based.

⁴⁸⁹ AQUA Action, Reducing Emergency Admissions 2011, https://www.aquanw.nhs.uk/system/uploaded_images/157/original/A4%20AQUA%20reducing%20emergency%20admissions.pdf?1319203605

- Assertive outreach case management by district nurses and community matrons (Castlefields health centre, Halton and St Helens PCT (2002)
- Virtual wards in the community operated by GPs (Wandsworth virtual wards 2010)
- Virtual wards in the community combined with predictive risk tools to identify patients (Croydon PCT virtual wards 2010)
- Improved clinical decision making in A&E (use of senior staff earlier in the process) (Nuffield Trust review of the rise in emergency admissions (2010).

The most robust evidence for admission avoidance is in mental health where having a designated 24/7 team responsible for gate keeping admissions to beds has demonstrated reduced rate of admissions.

Self-care, rehabilitation and re-ablement are critical elements of reducing primary demand for unscheduled care, reducing risk of readmission and delaying the need for residential care. There is also evidence that re-ablement and rehabilitation deliver cost benefits in addition to promoting independence and quality of life⁴⁹⁰.

A King's Fund report⁴⁹¹ found substantive evidence to support intermediate care that targets specific groups or illnesses or events (e.g. stroke and falls), strong evidence for secondary stroke prevention, and evidence of cost effectiveness for the primary prevention of stroke through dietary salt reduction and smoking cessation. It highlighted that in order to maximise the effectiveness of any intervention, it is important to target those who will benefit most.

NICE Clinical guidelines, CG68 (July 2008), Diagnosis and initial management of acute and transient ischaemic attack (TIA)⁴⁹².

NICE Quality Standards for Stroke 2011

Recommendations of NICE CG 68 focus on quick access to an acute stroke unit and CT scan, as well as tested for Fast (Face Arm Speech Test) or a similar test.

NICE Quality Standards (2010) for Stroke⁴⁹³ provide clinical best practice across the care pathway. These standards include 11 quality statements, covering care provided to adult stroke patients by healthcare staff during diagnosis and initial management, acute-phase care, rehabilitation and long-term management.

What is being done locally to address stroke?

NICE quality guidelines 2010 for stroke are being implemented locally across primary, community, acute and hyper-acute care settings.

There is an established early supported discharge provided in the community offered as outreach service by Whipps Cross University Hospital. Further, people with post stroke spasticity pathway are currently receiving evidence-based care and the local care pathway is now being consulted. More investment is required to strengthen this pathway. Both these services promote independence, reduce disability and promote wellbeing.

⁴⁹⁰ Herne S, Unscheduled care strategy in Waltham Forest 2011.

⁴⁹¹ http://www.kingsfund.org.uk/publications/appendices_to.html

⁴⁹² <http://www.nice.org.uk/guidance/index.jsp?action=byID&o=12018>

⁴⁹³ <http://publications.nice.org.uk/stroke-quality-standard-qs2/list-of-statements>

Stroke survivors and their carers now benefit from a dedicated stroke care co-ordinator in the community funded through the re-ablement funding. Dedicated support for carers is offered through the resource hubs, the first of which opened in Leyton in July 2011.

In July 2011 the London Borough of Waltham Forest commissioned the Stroke Association to provide two services to support stroke survivors. These include the Waltham Forest Stroke Navigator and the Waltham Forest Communication Support Coordinator.

The Stroke Navigator is funded full time, alongside a number of other community and voluntary sector agencies. The Navigator meets clients and family members for up to one year at hospital, and during the early stages of adjustment on return home to provide practical information, advice and support and act as a link across the stroke pathway between health, social care and longer term community reintegration.

The Communication Support Coordinator is funded three days a week. Referrals to the service, is largely from the community Speech and Language Therapy team. The Coordinator offers specific support to clients with aphasia and other communication difficulties following stroke.

Both services aim to help those affected by strokes to continue to live full lives, linking in with the seven outcomes of 'Our Care, Our Health, Our Say': Quality of Life, Health and Wellbeing, Making a Positive Contribution, Economic Wellbeing, and Freedom from Discrimination, Personal Dignity, and Choice and Control. Patient feedback is used to improve service delivery.

There has been steady progression on a number of evidence-based initiatives on heart failure locally. A community-based specialist heart failure service was established in November 2011 to provide a consultant support service to improve quality, equity and efficiency delivering care closer to home.

Over 70% of patient contacts are home visits which provide a unique way of providing holistic and individually tailored personal management plans. Visits by the specialist nurse not only gave them access to care that might otherwise not be available but also allowed to assess the home environment and pick up on additional issues which may be impacting on their health. This service is expected to reduce emergency admissions, length of stay of admitted patients, outpatient attendance at WXUH and will improve quality of care. An evaluation is planned at the end of one year. This service was funded by the reablement grant of the London Borough of Waltham Forest, which typifies true collaboration in care provision.

NICE Guidelines on heart failure recommends undertaking a Serum Natriuretic Peptides (SNP) screening test for patients with suspected heart failure before the diagnosis is confirmed by ECHO testing. This service was established on 1 May 2012 and funded through the reablement grant. This prevent referrals to ECHO testing which would have been necessary prior to SNP testing was in place and demonstrates expected savings.

An integrated care model (ICM) for people with complex health care needs who are at higher risk of readmissions to hospitals was commissioned in 2011. This is a proactive case management model to provide personalised care through joint collaboration of GPs, acute care, community care and social services. This model has been shown to be effective in achieving expected outcomes. Considering the higher rates of emergency admissions among 65+, this model has the potential to improve the quality of life of this group and to realise savings.

Priorities for improvement over the next five years for older people

- Needs of an ageing society with cultural diversity and high percentage of older people in more deprived wards in Waltham Forest
- High percentage of people 75+ living in isolation
- Inequalities experienced by older people
- Reducing premature mortality and improving life expectancy at age 65
- Promotion of good mental health and management of poor mental health including dementia

- Above average demand on acute care including dementia, SMI, CHD and stroke
- Need for targeting older people in some services such as cardiac rehabilitation, exercise referral scheme adjusted to their mobility requirements, integrated care model
- Scarcity of data on access and use of community services
- Coordinated approach to prevention of ill health and promotion of good health and wellbeing
- Examine local data on supporting older people with health and social care needs to live in a community setting, extra care housing and Assistive technology
- Prevention and treatment of stroke.

8.2 Older people: falls

What are falls?

Falls are commonly defined as ‘inadvertently coming to rest on the ground, floor or other lower level, excluding intentional change in position to rest in furniture, wall or other objects’⁴⁹⁴. The population of focus is people aged 65 years and over, living in Waltham Forest, because this is the most at risk population for falls.

Falls represent a significant public health challenge, with incidence increasing at about 2% per annum. Increased rates of people falling, and the severity of the consequences, are associated with growing older and the rising rate of falls is expected to continue as the population ages. In England, the number of people aged over 65 is expected to rise by a third by 2025. Preventing older people from falling is a key challenge for Public Health; however it is not the preserve of one agency as the consequences of a fall and resultant fragility fracture cuts across all local agencies working with older people. Most falls do not result in serious injury. However, there is often a psychological impact. Evidence suggests that approximately 25 percent of people aged 75 or over unnecessarily restrict their activities because of fear of falling. Due to consequences of falls such as fractures and fear of falling the physical, psychological and social functional abilities decrease which can have a considerable impact on perceived quality of life.

Risk factors

A number of variables associated with increased risk of falling have been categorised into intrinsic and extrinsic. Intrinsic risk factors are those that present within the individual including mobility, strength, gait, medicine use and sensory impairment. Extrinsic risk factors are those that are external to the individual including hazards within the home environment.⁴⁹⁵

The following are the risk factors⁴⁹⁶:

- Previous fall – 50% of those who fall will have another fall within the next 12 months
- Increasing age
- Environmental hazards, e.g. loose or slippery floor covering
- Musculoskeletal problems especially affecting the lower extremities, e.g. weakness, arthritis
- Dizziness
- Abnormality of gait or balance
- Visual impairment
- Neurological disease, e.g. Parkinson's disease, Stroke

⁴⁹⁴ WHO Global Report on Falls Prevention in Older Age, 2007.

⁴⁹⁵ Guidelines commissioned by the NICE (NICE), 2004: <http://www.nice.org.uk/nicemedia/pdf/CG021fullguideline.pdf>

⁴⁹⁶ Map of Medicine 2011; Falls in elderly people.

- Cognitive impairment, e.g. Dementia (including Alzheimer's disease), Delirium
- Cardiovascular problems: e.g. orthostatic hypotension; carotid sinus hypersensitivity; vasovagal syncope; postural hypotension (associated with increased morbidity and mortality, in part due to the increased incidence of falls)
- Drug therapy – hypnotics, sedatives, diuretics, antihypertensive
- Polypharmacy (four or more medications).

WHO categorized risk factors into four⁴⁹⁷:

- **Behavioural** – Multiple medication use, excess alcohol intake, lack of exercise, inappropriate footwear
- **Biological** – age, gender, race, chronic illnesses (e.g. Parkinson, arthritis, osteoporosis)
- **Environmental** – poor building design, slippery floors and stairs, loose rugs, insufficient lighting, cracked or uneven sidewalks
- **Socioeconomic**: low income and education levels; inadequate housing; lack of social interaction, limited access to health and social services, lack of community resources.

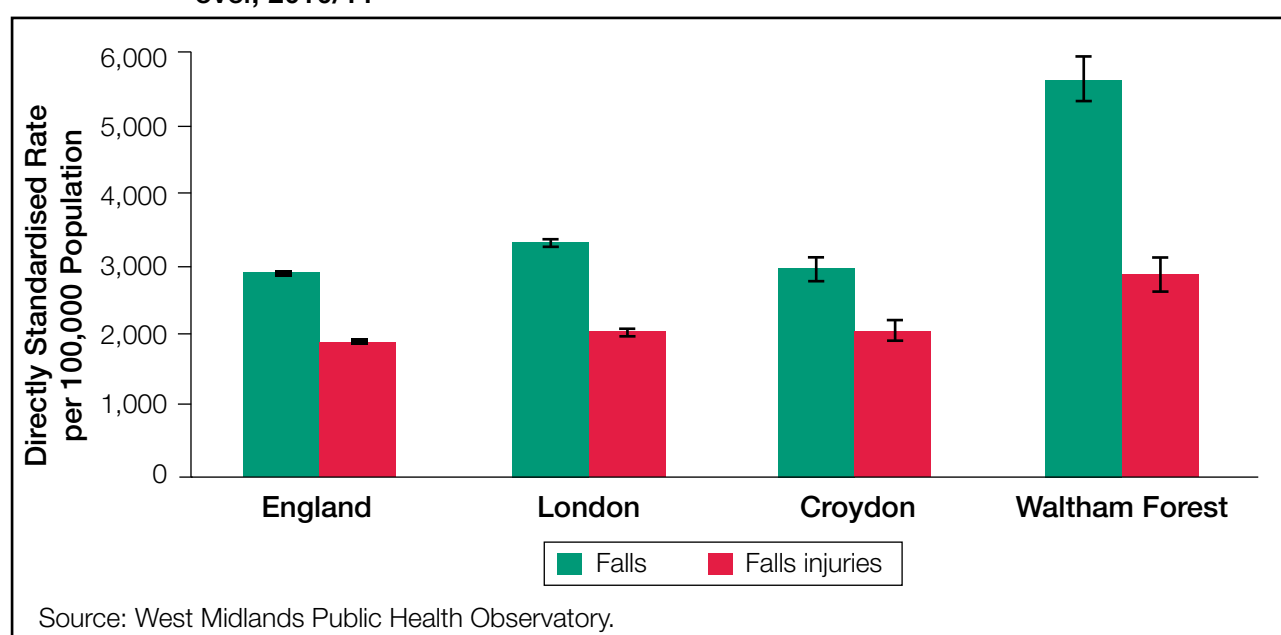
Local picture

Evidence suggests that about a third of people aged 65 and over will fall at least once a year⁴⁹⁸. This translates to about 7,900 people (aged 65 and over) in Waltham Forest.

Hospital admissions

Figure 8.8 illustrates that hospital admissions for falls and falls injuries in Waltham Forest are significantly higher than its comparators. It has been observed that falls injuries accounted for half of all the falls hospital admissions in Waltham Forest. This suggests about half of all the falls incidents may not require hospital admissions.

Figure 8.8 Hospital admissions due to fall and fall injuries, Waltham Forest, age 65 years and over, 2010/11



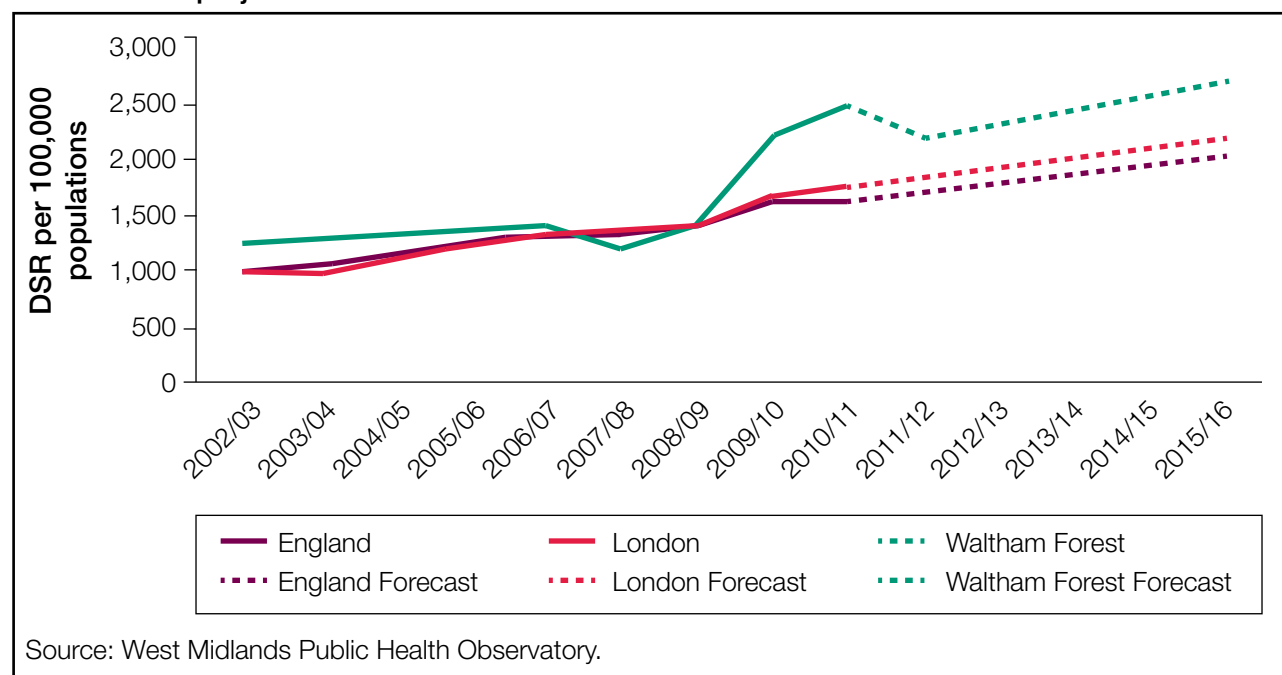
⁴⁹⁷ WHO Global Report on Falls Prevention in Older Age, 2007.

⁴⁹⁸ Gillespie LD, Gillespie WJ, Robertson MC, Lamb SE, Cumming RG, Rowe BH. Interventions for preventing falls in elderly people. Cochrane Database of Systematic Reviews 2003, Issue 4. Art. No.: CD000340. DOI: 10.1002/14651858.CD000340.

Admissions due to falls were highest in Lea Bridge, Markhouse, William Morris, Chingford Green and Hoe Street.

Figure 8.9 shows that Waltham Forest has higher hospital admissions for fall injuries than its comparators (England and London) between 2002/03 and 2010/11. The projection shows an upward trend suggesting that admission for falls in Waltham Forest may continue to increase.

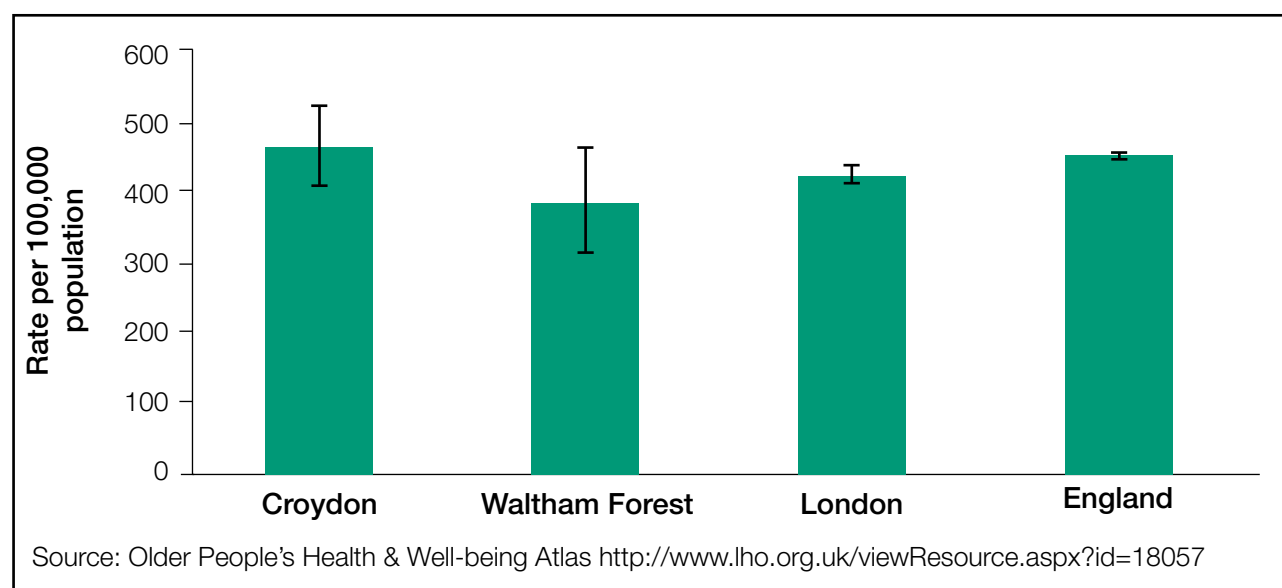
Figure 8.9 Hospital admissions for falls injuries in Waltham Forest (all ages), 2002/03 to 2010/11, projection 2015/16



Hospital admission for fractured proximal femur

Figure 8.10 shows that Waltham Forest has lower emergency admissions for fracture proximal femur than its comparators (England, London, Croydon) although the differences were not statistically significant.

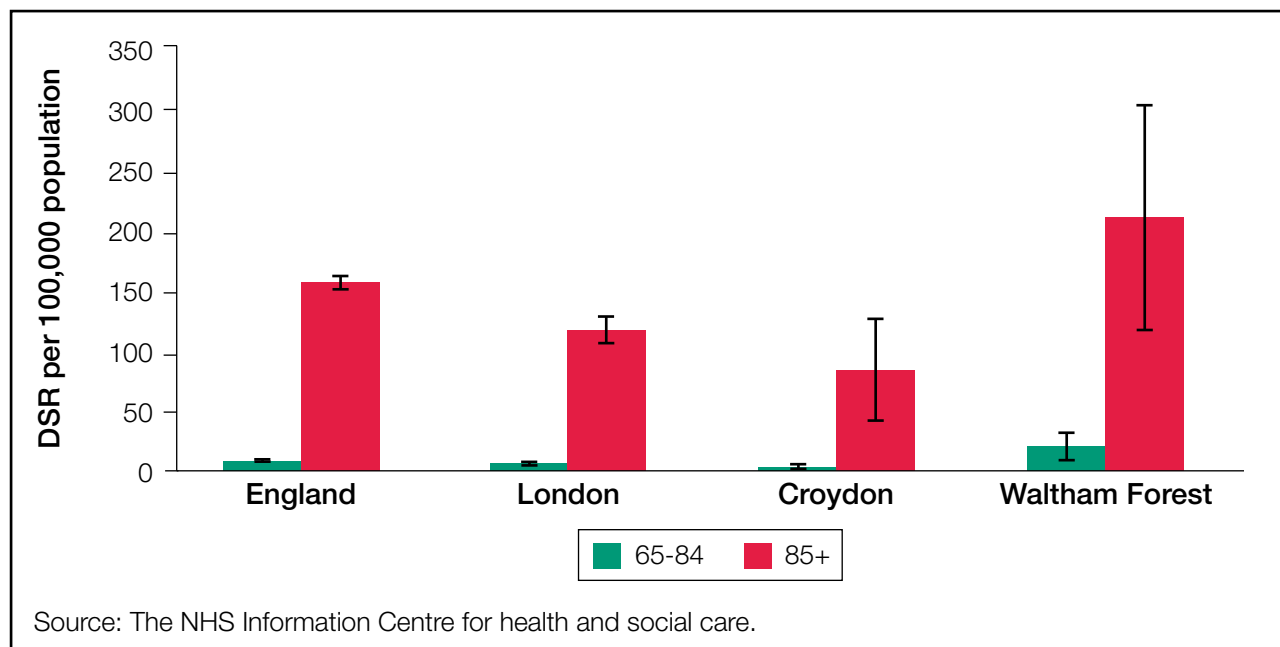
Figure 8.10 Emergency hospital admissions for fractured femur in people over 65 years of age (directly age and sex standardised) 2010/11



Mortality from fracture of femur

Figure 8.11 illustrates that Waltham Forest has a significantly higher mortality from fracture of femur for 65 to 84 years age group than its comparators. It also shows that Waltham Forest has a higher mortality from fracture of femur for over 85 years age group than its comparators, but many of the differences were not significant.

Figure 8.11 Mortality from fracture of femur, Waltham Forest, 2008–10 pooled



What are effective interventions?

NICE⁴⁹⁹ guidelines 2004 – cover assessment and prevention of falls in older people. Recommendations on good practice based on the best available evidence of clinical and cost-effectiveness include

- **Case and risk identification:** Older people in contact with health professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and the characteristics of the fall
- **Multifactorial falls risk assessment:** Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by healthcare professionals with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multifactorial intervention
- **Multifactorial intervention:** Older persons with a history of fall, or assessed as being at increased risk of falling should be considered for a multifactorial intervention
- **Encouraging the participation of older people in falls prevention programmes including education and information giving:** Individuals at risk of falling, and their carers, should be offered information orally and in writing about what measures they can take to prevent further falls
- **Professional education** – All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competences in falls assessment and prevention.

⁴⁹⁹ NICE 2004: <http://www.nice.org.uk/CG21>

The Department of Health National Service Framework (NSF) for older people (2001) was produced as a resource for local NHS organisations and local councils to help deliver high quality services for older people. Standard 6 focuses on falls and states⁵⁰⁰:

- The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their populations of older people
- Older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention through a specialised falls service.

This standard set out changes needed to reduce the number of falls and their impact through:

- Prevention – including the prevention and treatment of osteoporosis
- Improving the diagnosis, care and treatment of those who have fallen
- Rehabilitation and long-term support.

The care of patients with fragility fracture (Blue Book)⁵⁰¹ sets out standards for hip fracture care. These standards reflect good practice at key stages of hip fracture care. Widespread compliance with them would improve the quality and outcomes of care and also reduce costs. Compliance and progress towards compliance can be continuously monitored by participation in the National Hip Fracture Database:

Generally, Whipps Cross Hospital's performance is not too different from the national average, apart from one standard i.e. all patients with hip fracture should be admitted to an acute orthopaedic ward within four hours of presentation standard. See Table 8.4.

Table 8.4 Six standards for hip fracture care performance, 2013⁵⁰²

Standards	National Average	Whipps Cross Hospital
All patients with hip fracture should be admitted to an acute orthopaedic ward within four hours of presentation.	51.6%	18.3%
All patients with hip fracture who are medically fit should have surgery within 48 hours of admission, and during normal working hours.	87.3%	89.5%
All patients with hip fracture should be assessed and cared for with a view to minimising their risk of developing a pressure ulcer.	3.5%	4.1%
All patients presenting with a fragility fracture should be managed on an orthopaedic ward with routine access to acute orthogeriatric medical support from the time of admission.	6.1%	5-10%
All patients presenting with fragility fracture should be assessed to determine their need for antiresorptive therapy to prevent future osteoporotic fractures.	12%	5-10%
All patients presenting with a fragility fracture following a fall should be offered multidisciplinary assessment and intervention to prevent future falls.	67.5%	78-80%

⁵⁰⁰ National Service Framework for Older People: standard 6 falls.

⁵⁰¹ British Orthopaedic Association 2007: The care of patients with fragility fracture (Blue Book).

⁵⁰² The National Hip Fracture Database National Report (2013): http://www.nhfd.co.uk/003/hipfractureR.nsf/NHFDNationalReport2013_Final.pdf

What is being done locally to improve falls prevention and care?

Primary care

GPs may see patients who have had a fall, high risk of falling or with balance problems but do not require emergency intervention. GPs can assess the risk of falls or assess the likely cause of a fall by reviewing the individual's medication and a blood pressure check for postural hypertension.

There are some conditions or causes of falls that can be treated in primary care, such as visual impairment and urinary incontinence, which may lead to a reduction in the risk of falling.

Secondary care

The Fracture Clinic – Outpatients Department at Whipps Cross Hospital offers a service for patients who have been referred by Accident and Emergency or have previously been inpatients having had treatment for an acute injury.

The Falls Clinic is based at Connaught Day Hospital, Whipps Cross Hospital. It is a Consultant Geriatrician led, multi-disciplinary specialist falls assessment service. Referrals to the clinic are made from GPs, from A&E and other consultants. The clinic runs balance classes and a Falls Education Group.

The Osteoporosis clinic takes referrals from GPs, hospital consultants or private patients. Treatment offers:

- Osteoporosis Assessment following fracture for 50-year-olds and over from A&E to assess the strength of their bones
- Appointments with the Fracture Liaison Nurse for those aged 50 to 64 with osteoporosis
- A scan followed by an appointment with the Fracture Liaison Nurse for those aged 65 to 74 for treatment and lifestyle advice.

Community services

Ainslie Rehab Unit Chingford offers an eight week balance class one day a week aimed at improving balance and confidence in people who have fallen or are afraid of falling. The group consists of up to six people participating in a circuit class, which incorporates different balancing activities and exercise components at each workstation.

The National Osteoporosis Society Support Group for residents in the borough meets bi-monthly meetings for service users who have osteoporosis or have been diagnosed to be at risk from osteoporosis. The support group offers information, support and medical updates.

Waltham Forest Inter Care Services support service users experiencing a crisis, such as a fall, to regain and maintain functional independence and restore their confidence. Inpatients Units are for people who cannot go home and would usually need a short period of rehabilitation, and Community Service is for people who require a short period of rehabilitation at home, in supported housing, in nursing and residential care environments.

Social care and prevention

Age UK Waltham Forest provides two services, including:

- The Wellbeing programme delivers a range of accessible exercise/balance classes to older adults in partnership with local organisations from a number of community venues across the borough with the view to prevent falls and improve health and wellbeing
- Age UK Case Finding uses a proactive approach to identify older people at risk of preventable deterioration, accident or crisis.

Waltham Forest's Council's Reablement Service provides planned, short term, intensive support. It is designed to help a person restore independence and confidence, as well as to support them to do as much as they can for themselves. Someone who has fallen might be referred to the reablement service if they would benefit from some additional support in regaining skills and confidence.

Waltham Forest Telecare and Community Alarms are used to enable vulnerable people to maintain independence and security within their homes. The service uses technology linked to a response centre. Telecare builds on community alarm system, which allows people to call for help in an emergency by pulling a cord or a pendant worn around the neck.

What evidence is there that we are making a difference?

Table 8.5 sets out progress achieved since the 2012/13 JSNA.

Table 8.5 Progress since the 2012/13 JSNA

Recommendations JSNA 2012/13	Progress
Develop a Falls Prevention Strategy and refresh the current multi-agency steering group.	Draft Strategy document completed July 2013 and presented to Waltham Forest CCG. Awaiting pathway to be confirmed.
Pathway development and service redesign to incorporate integrated falls prevention, treatment and management pathway.	Integrated pathway developed – waiting to be agreed subject to Waltham Forest community service model being finalised. GP falls care pathway developed.
Incorporate falls prevention and awareness into mainstream health and social care services, with criteria for identifying people suitable for falls assessment and evidence-based interventions.	Falls Awareness Campaign delivered by Waltham Forest Age UK successfully. Two events were delivered in the borough with good turnout, with one event scheduled for 21 November 2013.
Improve local data and information sharing among the partnerships, including collecting data from the community and from older people in residential care to identify total incidence of falls. This could help establish whether the consequences of a fall are more serious in different groups (demographic or geographical).	Falls risk register in the care homes, sheltered care housing and extra care schemes have been set up, implementation is taking place.
Improve rehabilitation services for people who have lost functional ability or confidence after a fall.	New community services model is currently being finalised. The proposed community falls service will be integrated within the community rehabilitation team.

What is the perspective of the public on support available to them?

National research has identified several barriers to accessing falls prevention services, including⁵⁰³:

- Lack of information for non-English speakers
- Lack of family support
- Social stigma attached to programmes specifically targeted at 'older people'
- Barriers to physical activity include low confidence and health expectations, pain and effort
- Lack of transport to venues where activities are held.

⁵⁰³ Adapted from Tower Hamlets JSNA 2010/11.

What more do we need to know?

Evidence suggests that hospital admissions for falls are increasing. However, there are still a number of people who experience falls that are not reported. Falls attendances at Whipps Cross are increasing. The problem is how the falls are coded at A&E, as older people often present with a number of comorbidities.

There is a need to review the current services in the acute sector where Whipps Cross underperformed, particularly in the following standards of the Blue book, which state that:

- all patients with hip fracture who are medically fit should have surgery within 48 hours of admission, and during normal working hours
- all patients with hip fracture should be assessed and cared for with a view to minimising their risk of developing a pressure ulcer
- all patients presenting with a fragility fracture following a fall should be offered multidisciplinary assessment and intervention to prevent future falls.

8.3 Other issues affecting older people

Urinary tract infections (UTI) among older people

Urinary tract infections among people aged 70 and above have been a major cause of emergency admissions through A&E with a rapid increase over the three-year period from 2007/08. The mean length of stay was 16 days. These could be prevented through protocol-based integrated care pathways jointly across health and social care. Patients aged 80+ had the highest spells of admissions.

In 2009/10, older people with UTI admitted to WXUH (Whipps Cross University Hospital) resulted in:

- 360 people generating 422 admissions
- Mean length of stay (LoS) – 16.3 days at cost of £1.2 million
- One in six admitted within 14 days
- Around 80% discharged to normal place of residence⁵⁰⁴.

Disabilities among older people in Waltham Forest

Hearing and visual impairment and restricted mobility are the leading disabilities associated with older people. Numbers of people affected in 2012 in Waltham Forest are set out in Table 8.6 below, along with projections up to 2020.

Table 8.6 Current and projected numbers of people 65+ with hearing and visual impairment

Disability	2012	2014	2016	2018	2020
Moderate or severe hearing impairment	11,055	11,132	11,139	11,339	11,580
Moderate or severe visual impairment	2,291	2,333	2,337	2,384	2,432
Registrable eye conditions	781	794	787	800	813
Restricted mobility	4,774	4,857	4,893	4,992	5,114

Source: Projecting Older People Population Information (POPPI).

Winter deaths

There were on average 87 excess winter deaths per year in Waltham Forest between 2008–11. This represents a ratio of excess winter deaths of 25.9 for Waltham Forest, which is above the London average of 21.8 and England average of 20.9.⁵⁰⁵ Ratio of excess winter deaths = (observed winter deaths minus expected deaths based on non winter deaths)/average non winter deaths.

For every additional winter death nationally, there are also around 8 admissions to hospital, 32 visits to outpatient care and 30 social services calls⁵⁰⁶.

⁵⁰⁴ Rahman J and Herne S, Presentation on Waltham Forest Health Economy, Unscheduled Care Programme, Briefing for Polysystem Boards 2011.

⁵⁰⁵ Older People's Health and Wellbeing Atlas.

⁵⁰⁶ Reducing winter deaths. Age UK. Available from: <http://www.ageuk.org.uk/get-involved/campaign/preventing-winter-deaths/>

8.4 End of life care

What is end of life care?

End of life care is defined in the national end of life care strategy 2008 as care that helps all those with advanced, progressive and incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support. However, the term 'end of life' is gradually being replaced by 'last years of life' recognising the difficulties in prognostication particularly in frailty, advanced COPD and heart failure. The cancer story is changing too, with increasing numbers of people living longer with incurable cancer. 'Last years of life' recognises these uncertainties, and seems a less stark term than 'end of life.' This can make it easier for health professionals to broach conversations with their patients about what is important to them towards the end of their lives.

The Department of Health has developed three tools to support health care professionals to do this:

- The Gold Standards Framework supports early identification of patients who may die in the next 6 to 12 months and enables assessment of their needs, advance care planning and open discussions with patients. Although developed for use in primary care it can be used in care homes and for all disease groups
- The Preferred Priorities of Care document aims to facilitate patient and carer choice, enabling them to document their priorities, and share this with health professionals, e.g. preferred place of death
- The Liverpool Care Pathway has been discontinued in Waltham Forest following the Neuberger report 2013. It will be replaced by a personalised end of life care plan, backed up by good practice guidance specific to disease groups. It is hoped that this will be finalised by the end of 2013.

End of life care is a key central government priority and is part of NHS outcome framework, aiming at improving the experience of care for people at the end of their lives. This include ensuring that people die in dignity and with a choice of service provision including help to remain in their own homes until they die, should that be their wish.

Local picture

Mortality

Age standardised mortality rates for all causes, all ages are significantly higher in Waltham Forest than the national and London average for both males and females. In 2008–10 Waltham Forest age standardised mortality in males was 728.6 per 100,000 population compared to 656.0 nationally. This is the eighth highest in London. For females in Waltham Forest, age standardised mortality was 494.6 per 100,000 population compared to 467.1 per 100,000 population nationally. This is the eighth highest rate in London. On average there are 1,460 deaths in Waltham Forest annually. 59% of these are people aged 75 years and above. This is in line with the national trend, where two-thirds of people die aged 75 or over with a recent trend towards an increase in deaths in the over 85s.

The causes of death change with increasing age at death – Alzheimer's, dementia, frailty, pneumonia and stroke becoming more common. The place of death changes too, with a higher proportion of the extreme elderly, who are more likely to be women, dying in nursing or old people's homes. This in part reflects the frailty of many elderly people before death, which often results in the need for 24-hour care; which clearly highlight the changing end of life care needs as the population ages.

For Waltham Forest this points to the need to:

- Skill up the professionals and have clear pathways to be able to address the end of care needs linked to frailty of many elderly people before death
- Increase capacity to meet the demand for nursing homes or old people's homes
- Provide 24 hour care to ensure high quality service in the community and reduce unnecessary hospital admissions.

Socio-cultural challenges relating to end of life care

Ethnicity

Historically in the UK, it appears that ethnic minorities have not had access to specialist palliative care as much as would be expected according to their percentage in the population. The reasons for this are not fully understood, but include low referral rates and lack of knowledge of services.

There is evidence that the religious needs of some South Asians and black Caribbean's have not been well catered for, however, hospices have been shown to be sensitive to the religious and cultural needs of minority patients, and patients and families are largely happy with the care received. Language barriers are probably the most significant reason for the needs of non-English speakers not being met.

It is not known whether there is unmet need among ethnic minority patients in Waltham Forest in respect of access to specialist palliative care, whether language barriers are overcome and patients receive care that is sensitive to their religious and cultural needs.

Given the high incidence and high morbidity of diabetes and heart disease in the BAME population in the borough, an increased need for palliative care in end stage renal disease (ESRD) and heart failure can be predicted. This means for Waltham Forest there is need to:

- develop heart failure and renal disease pathway
- liaise with the heart support team
- work jointly with the renal support team
- consult with BAME groups to determine their preferences for end of life care.

Palliative patients' identification

A recent study in England showed that 69% to 82% of those who die need palliative care.⁵⁰⁷ In Waltham Forest approximately 1,429 people die every year and using this formula it indicates 986–1,172 people would need palliative care. The 2013/14 GP palliative registers show that there 465 patients on the register which means the palliative registers in primary care captures less than half (47%) of the people needing palliative care. However, QOF data reflect the number of people on the palliative registers at one point in time not the entire year so there may be some slight underestimate. There is a need to work with primary care to continue developing the Gold Standard Framework (GSF) and to support GPs to identify more patients in need of palliative care.

⁵⁰⁷ Fliss EM Murtagh, Claudia Bausewein, *et al.* (2013). How many people need palliative care? A study developing and comparing methods for population-based estimates. *Palliative medicine*. Available at <http://pmj.sagepub.com/content/early/2013/05/20/0269216313489367>

Place of death

According to national end of life care intelligence network, 3,078 deaths (from all causes) occurred in hospital in Waltham Forest between 2008–10. This represents 70.2% of all deaths, which is significantly higher than average proportion of hospital deaths nationally (54.5%) and in London (63.7%). See Table 8.7 below.

Table 8.7 Place of death proportion in Waltham Forest compared to London and England average, 2008–10

Place of death	Waltham Forest		England
	Number	%	%
Hospital	3,078	70.2	54.5
Own home	750	17.1	20.3
Residential care and nursing home	435	9.9	17.8
Hospice	24	0.5	5.2
Elsewhere	97	2.2	2.2

Source: National End of Life Care Intelligence Network, 2008–10 average.

Waltham Forest is ranked as having the highest hospital deaths in the country. However it should be noted that the data captured here include deaths in Margaret Centre which is a hospice within Whipps Cross Hospital and those deaths have been included as hospital deaths. The Office for National Statistics place of death statistics only counts deaths in a hospice building. Deaths in a hospice/palliative care unit in an NHS hospital or receiving the support of a Hospice Home Care Team cannot be captured with routine statistics.

According to Margaret Centre data between 2010 and 2012 there were a total of 1,072 deaths which gives an average of 357 deaths each year. When we take these data into account, and subtract the Margaret Centre deaths from the Whipps Cross total, deaths in the acute hospital setting, then Waltham Forest hospital death is similar to London average.

Between 2008–10, the major disease areas that contributed to hospital deaths in Waltham Forest are respiratory, circulatory and cancer see Table 8.8 below. The National Audit Office report for end of life care suggested that up to 35% of people who die in hospital could die in other settings.

Table 8.8 Place and cause of death

	All causes	Underlying cause of death			Causes mentioned on death certificate			
		Cancer	Cardiovascular disease	Respiratory disease	Alzheimer's/ Dementia/ Senility	Liver disease	Renal disease	Respiratory disease
Home	250	63	96	23	11	17	6	52
Care home	145	37	34	23	69	1	2	50
Hospital	1,026	262	300	163	107	48	75	428
Hospice	8	7	0	0	0	0	0	0
Total	1,461	375	436	212	188	67	84	537

Source: ONS Mortality Data 2008–10.

*'Underlying cause' of death is the main cause of death recorded on a death certificate. 'Causes mentioned' include the underlying cause and any contributory causes recorded.

What are effective interventions?

The Department of Health End of Life Strategy (July 2008) states a 'good death' for many would involve:

- being treated as an individual, with dignity and respect
- being without pain and other symptoms
- being in familiar surroundings
- being in the company of close family and/or friends.

Responsibility for the End of Life Care Strategy moved from the Department of Health to the NHS Commissioning Board in April 2013. The Strategy spans three domains of the NHS Outcomes Framework with its 'home' domain in long-term conditions. End of life care has been incorporated into the QIPP workstreams and adopted as its key performance indicator death in usual place of residence [DiUPR]. This combines peoples' own homes and care homes. This has been increasing, both in London, which had the lowest baseline, and in the Southwest which had the highest baseline. It is thought the ceiling has not yet been reached. Two other KPIs are under consideration, both aiming to reduce the amount of time spent in hospital in the last year of life.

Acknowledging that end of life care spans both health and social care, in the Social Care White Paper the Government recognises that these KPIs will entail improving community-based services, including care in care homes. Palliative Care funding pilot sites are currently collecting data on the potential costs of providing free health and social care at the end of life, as proposed in the White Paper.

The End of Life Care Strategy aims to improve the provision of care for all adults approaching the end of their life. The Strategy centres on:

- Improving the provision of community services by, for example, making rapid response community nursing services available in all areas 24 hours a day, seven days a week; and improving coordination of care between local authorities and the NHS
- Equipping health and social care staff at all levels with the necessary skills to communicate with, and deliver care to people approaching the end of life, and their carers
- Developing specialist palliative care outreach services by encouraging the NHS and hospices to work together to provide appropriate support to all adults in the community, regardless of their condition.

Health care for London has identified six quality markers for end of life care and recommends PCTs to incorporate these standards in their contracts with provider organisations:

- Identification of patients
- Care planning
- Co-ordination of care
- Communication skills
- Support to nursing and residential homes
- Discharge to preferred place of care.

A recent survey on public preferences for place of death shows 89% of the participants wanted to die at home or in a hospice. However other qualitative studies demonstrate that the preference for home as a place of death declines with the progression of illness and is less among carers. Hospital will remain the place of death for a large proportion of the population in the foreseeable future. It is therefore important to place equal emphasis on improving the quality of care in hospitals as in facilitating deaths in community settings.

The provision of end of life care services has become increasingly complex. People are living longer and the incidence of frailty and multiple conditions in older people is increasing. As a result, people approaching the end of their life require a combination of health and social care services provided in the community, hospitals, care homes, or hospices. There is need to ensure that the different providers give a seamless service.

What is being done locally to address this issue?

Palliative patients' identification

There is scope for increasing the numbers of patients on palliative care registers in primary care; although there is an upward trend (28% increase since 2010/11). The GP palliative register capture less than 50% of people who potentially need palliative care, it is essential to improve patient identification to ensure people in need of palliative care are receiving it.

The 'find your 1%' campaign, led by the National End of Life Care Programme (NEoLCP) is engaging with key partners such the RCGP to encourage practices to find their 1% of patients who may die in the next year. These patients should then be placed on the palliative register, with care planning and PPC (Preferred Place of Care) to follow. Practices should aim to increase the number of patients with diagnoses other than cancer on their registers. There is scope for promoting this locally.

The Amber Care Bundle is intended for use in secondary care when recovery is uncertain, and has been developed in Guy's and St Thomas' Hospital. It promotes best clinical practice and palliative care alongside active treatment. This could be selected as a CQUIN for Whipps Cross.

Co-ordination of care

To date, GP send their out of hours (OOH) handover forms to PELC (Partnership of East London Cooperatives), this enables the OOHs GPs to be informed of patients clinical condition and their wishes concerning PPC and resuscitation. However, this information does not pass also to London Ambulance or Whipps Cross A&E. Information sharing with district nurses, community SPC nurses and the ICT team occur at GP ICT/palliative meetings. There have been some recent instances reported by district nurse leads of patients with palliative care needs being discharged from hospital on a Friday afternoon without communication to GPs or district nurses, resulting in distress to patients and carers.

There is clearly a need for an electronic register that is accessible to all clinical staff who will care for patients either in the hospital or in the community. 'Co-ordinate my care' is an example of an electronic register in use elsewhere in London. At the time of writing, it does not appear that this will be compatible with local systems. However, a feasibility study to determine what may be possible locally is urgently needed.

Primary care

The most recent education events open to all GPs on cancer and palliative care took place in summer 2011. These were rated highly by those who attended. However, uncertainties about how best to obtain funding for further GP education has prevented further events. There is need to secure funding for GP training to ensure they are skilled enough to provide appropriate end of life care.

Secondary care

- A new palliative care consultant has been appointed at the Margaret Centre. Her remit includes some responsibility for palliative care in the community. As this is a recent appointment, details of how her role will develop in respect of this is awaited. She plans to continue palliative care education for DNs
- The Liverpool Care Pathway has been suspended with plans to replace it with a personalised care plan (LPC) across the Trust
- The 'Rapid Discharge of the Dying Patient Pathway' to enable choice at end of life for those who wish to return home has not been in frequent use. It is not known if this is due to lack of patient knowledge of, or demand for the service

- There is ongoing development of staff within the specialist palliative care team
- Regular extended multidisciplinary team meetings for heart failure and COPD patients continue with some joint visits undertaken with the new palliative care consultant.

Community

- The community matrons have been working closely with four nursing homes: Albany, Aspray, Heathlands and Rosswyld. They facilitate discussions with patients, relatives and nursing staff when it appears a patient is nearing the end of their life. They instigate advance care planning and elicit their preferred place of care. This has prevented unwanted hospital admissions. In 2011 an audit showed 95% of patients achieved their preferred place of care (PPC). The specialist palliative care team at the Margaret Centre acts as a source of support and advice for community matrons. All four care homes are working toward GSF (Gold Standard Framework) care home accreditation
- The integrated care team has now become more established with regular visits to GP practices. Their service is mainly for the frail elderly with complex needs living in their own homes. They case manage them to improve their quality of care and reduce hospital admissions. Many of these patients have life limiting conditions and as they age may be nearing the end of their lives. A need can be anticipated for advance care planning and PPC documentation for these patients
- There is a need for the community matrons caring for these patients to possess the communication skills and background knowledge which will facilitate open discussions with patients and elicit their PPC
- Community matrons are availing of palliative care education at St. Josephs Hospice, ideally all community matrons should be trained to the same level of competency in end of life care.

District nurses

District Nurse leads report that DN teams are increasingly dealing with complex packages of care in very short time frames. This impacts on the time available to them to offer terminal care to patients choosing to die in their own homes. The disbanding of the OOH palliative nursing team has also placed a strain on staff covering 5 to 9pm. Overnight, one or two pairs of DNs now cover all of Waltham Forest and Redbridge. This is resulting in delays in reaching patients and nurse time being wasted travelling due to the distances involved.

What more do we need to know?

- Local people's views on palliative care provision in the borough and establish what their needs and priorities for palliative care are
- Improve data on palliative registers in primary care and on place of death
- Improve understanding of end of life care need and provision for minority groups (BAMEs, disabled, lesbian/gay, homeless) in Waltham Forest. Establish what their needs and priorities for palliative care are
- NICE guideline and Improving Outcomes Guidance (IOG) in end of life care stipulate that 24/7 specialist palliative care cover should be in place to ensure generalist services have access to advice for cases with complex needs or symptoms which are difficult to manage. Waltham Forest currently is non-compliant with this requirement. A lack of prompt access to services in the community leads to people approaching the end of their life being unnecessarily admitted to hospital. Studies show that absence of 24-hour response services and timely access to advice and medication leads to unplanned admissions
- End of life care provision for children and young people in the borough – level of need, services available, children and young people's needs and priorities.

Priorities for improvement over the five years

- Commission provision of out of hours specialist palliative care support for generalists working in the community and for hospital specialists
- Identify and assess more patients needing palliative care and encourage open discussion with patients and families when the end of life is near
- Consult with the public to establish local palliative needs and priorities, and develop a targeted strategy to meet these needs
- Embed best practice recognised end of life tools in all sectors of health care provision to enable people approaching the end of their life to live and die in the place of their choice and provide best care for the dying
- Secure funding for upskilling the staff on end of life care, e.g. GPs, district nurses etc
- Education of professionals (primary, secondary and community) to address gaps in skills particularly communication, assessment and identifying patients needing palliative care, and in diagnosing dying
- Commission an increased number of district nurses to provide palliative care in the community, as we shift deaths from the hospital to the community. This will reduce unnecessary hospital admissions
- Develop clear pathways for end of life care in the disease groups with highest mortality – CVD, respiratory diseases and cancer
- In order to meet the 50% target of people dying in community (hospice, care homes, nursing homes own residence) in line with NHS Commissioning Support for London recommendation, commissioners need to invest in acute services to ensure adequate capacity for rapid and seamless discharge to community
- Improve communication between the different professionals and care givers in end of life pathway and provide an integrated service for palliative patients. There is an urgent need to implement an electronic register
- There is need to recruit more district nurses and reinstate some form of OOH palliative care nursing team
- More effective joined up discharge planning from Whipps Cross. Amber Care bundle to be nominated as CQUIN.

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